DOCUMENT RESUME

ED 219 460 TM 820 495

TITLE Health Assessment and Teaching Performance Examination: Study Guide.
INSTITUTION New York State Education Dept., Albany. Cultural Education Center.
PUB DATE Jan 82
NOTE 167p.

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS Criterion Referenced Tests; *Health Materials; *Medical Care Evaluation; Medical Case Histories; *Nursing Education; Physical Examinations; Postsecondary Education; *Study Guides; Test Coaching
IDENTIFIERS Regents External Degree

ABSTRACT

The Health Assessment and Teaching Performance Examination (HATPE), a criterion-referenced examination, requires the application of theory and competence in the performance of health assessment and teaching. The HATPE incorporates the theory related to history taking, physical examination and organization of a summary of data as well as the specific technical skills involved in the physical examination. In addition, the candidate is tested on the ability to identify and describe simulated heart and breath sounds. Candidates shcuild be knowledgeable in all of these areas, prepared to take and record history, and perform and record a physical examination on a generally healthy client. The candidate will organize the data in order to develop a plan for nursing action. The HATPE is equivalent to the final examination of a college course in theory and practice of health assessment, requiring knowledge of process and content related to a broad spectrum of client health care problems and nursing responses. This study guide describes and explains critical elements of the examination, and resources/learning activities. The bibliography contains suggested references and study materials including a section which illustrates and describes requirements for each area to be tested. (Author/PN)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED219460

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

R. Trombly

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Study Guide

HEALTH ASSESSMENT AND TEACHING PERFORMANCE EXAMINATION

Second Edition
January 1982

THE UNIVERSITY OF THE STATE OF NEW YORK
Regents External Degree Nursing Programs
Room 5D45
Cultural Education Center
Albany, New York 12230
(518) 473-8957

Copyright © 1981, by THE UNIVERSITY OF THE STATE OF NEW YORK REGENTS EXTERNAL DEGREES IN NURSING. This book is fully protected by copyright and no part of it may be reproduced in any form by print, photoprint, microfilm, or by any other means without the written permission of the publishers.

The University of the State of New York does not discriminate on the basis of age, color, creed, disability, marital status, veteran status, national origin, race, or sex. This policy is in compliance with Title IX of the Education Amendments of 1972.

TABLE OF CONTENTS

		Page
I.	General Information	1
II.	Part I - Health Assessment	
	A. Critical Elements	20
	B. Explanation and Suggested Learning Activities	37
	C. List of Acceptable Abbreviations	65
	D. Sample Health Assessment Records	66
	E. Blank Health Assessment Records	85
	F. Simulated Heart and Breath Sounds Critical Elements, Explanation and Answer Forms	104
	G. Bibliography	108
III.	Part II - Teaching	
	A. Critical Elements	115
	B. Explanation and Suggested Learning Activities	119
	C. Potential Teaching Topics	122
	D. Sample Teaching Answer Sheet	123
	E. Blank Teaching Answer Sheet	127
	F. Bibliography	129

THE UNIVERSITY OF THE STATE OF NEW YORK
REGENTS EXTERNAL DEGREE PROGRAM
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

OFFICE OF INDEPENDENT STUDY
PROGRAMS DEVELOPMENT

DEGREE PROGRAMS IN NURSING
518: 473-8957

Health Assessment and Teaching Performance Examination (HATPE)

Study Guide

I. General Information

The Health Assessment and Teaching Performance Examination is divided into two separate sections: Part I - Health Assessment and Part II - Teaching. The two sections are administered as one examination requiring one appointment, unless one part has been waived by previous course work. Special appointments will be made for candidates who waive either part of the examination. The candidate is not allowed to have the Study Guide during the exam, but will have the recording form the entire time.

The HATPE is a criterion-referenced examination, which differs significantly from standardized multiple choice paper and pencil tests. In standardized (norm-referenced) examinations, students are measured against the scores achieved by other students throughout the country; in these exams a certain percentage of items may be failed without failing the entire test. However, in criterion-referenced tests (like the HATPE), candidates are required to meet a pre-established standard of behavior without exception. In the HATPE these behaviors are called critical elements. Because the competencies are set at the minimum level acceptable for BSN graduates, all critical elements (100%) must be correctly performed for the prescribed number of areas. It is mandatory, therefore, that candidates meet the criteria of the standard (all of the critical elements) within an area with 100% accuracy. The concept of 75% or even 90% accuracy simply does not apply to this type of performance examination. To expect less than 100% of this baseline of acceptable performance would undermine beliefs about professional level nursing practice. Because of the nature of this examination it is important to realize that all aspects of all test items must be completed during the test period. The omission of even one aspect of a critical element may lead to failure of the area or the entire examination. Although the candidate should strive for 100% accuracy in each of the identified areas, the minimum passing requirement has been established to allow for anxiety, stress, fatigue or other factors related to the examination process. See Section VII. Criteria for Passing the HATPE, pp. 10-12, for the specific requirements.

PART I - Health Assessment Examination. Section A of the examination evaluates the candidate's ability to perform a comprehensive assessment with a generally healthy individual. The purpose of health assessment is to gather client-related data in an organized, systematic way so as to identify actual or potential health problems, and to assist the client to maintain an optimum level of wellness. It includes a health history, physical examination and a summary and analysis of the data. Candidates also are tested on their ability to identify normal and abnormal heart and breath sounds, reproduced on an audio tape for purposes of this simulated portion of the test during Section B of the Health Assessment Examination.

Objectives for the Health Assessment Performance Examination

The candidate will:

1. Interview a client to elicit data for the health history.
2. Perform a physical examination.
3. Record the required information in an organized, systematic way.
4. Describe common normal/abnormal findings.
5. Synthesize assessment data to ascertain the health status of client.
6. Identify a health maintenance problem.
7. Summarize the subjective and objective data relevant to the identified health problem.
8. Make clinical decisions based on the assessment of subjective and objective data.
9. Design a plan for nursing action relevant to the problem.

To pass the examination, the candidate must complete all of the critical elements listed in the examination study guide. The history includes such typical sections as: reason for contact, the exploration of current health status, family health history and review of systems. The physical examination includes four areas that are required of all candidates: general survey, heart, chest and lungs, and abdomen. A random selection of 2 other areas also will be tested, including such areas as: cranial nerves, reflexes, head and neck and circulatory status. Candidates will be tested on a random sample of areas and therefore should be prepared to demonstrate critical elements in every area.

Candidates who have difficulty understanding the requirements of the examination after reading this study guide, are encouraged to contact a nursing advisor at the central office in Albany.

The history interview conducted by the candidate is tape recorded; if discrepancies appear in the written history report, the tape is used to verify the client's comments. During the physical examination the Evaluator remains with the candidate at all times to document performance of all critical elements. Since this is a performance examination candidates are not asked to orally explain their actions. After the history and physical examination portions of the test are completed the candidate is required to complete the recording of all data and to analyze it on the form provided. Five hours is allowed for the four sections of Part I of the examination.

PART II - Teaching. This portion of the examination tests a candidate's ability to identify a client's learning needs, the objectives, content and methodology to be used in the brief teaching episode, and to present the material in a live situation. The candidate also must evaluate and record the outcome of the teaching-learning episode. The candidate will do the physical assessment with one client and the teaching portion with a different client.

Objectives for the Teaching Performance Examination

The candidate will:

1. Interview the client to clarify the learning need in relation to the problem.
2. Write one client-oriented objective to be achieved in a 15 minute teaching session.
3. Identify a specific learning outcome that is measurable in this session.
4. Write a teaching plan consistent with the client's learning need and level of knowledge.
5. Implement the teaching plan.
6. Evaluate the teaching session based on the learning outcome.

The content to be taught will focus on an aspect of health related to the learning needs of the client, rather than on techniques requiring the manipulation of equipment. Content areas may include such topics as: nutrition, lack of understanding of birth control, hazards of smoking, or lack of understanding a given health problem. After a brief interview with the client the candidate is required to meet the designated critical elements during the one hour which is allowed for this portion of the examination. The potential teaching topics are listed in the Teaching Performance section of the study guide. The candidate is expected to be prepared to teach in any of the content areas according to acceptable teaching and learning theory.

II. Application, Fees

A. Eligibility for Health Assessment and Teaching Performance Examination (HATPE)

Any candidate enrolled in the BSN External Degree Program is eligible to apply for the examination. It is strongly recommended that the candidate

successfully complete the five written nursing examinations and practice physical assessment and teaching using the HATPE study guide before taking the exam. A candidate who is eligible and prepared to take the exam should request an application and/or study guide from:

Nursing Program - HATPE
Regents External Degrees
Cultural Education Center
Albany, New York 12230

B. The HATPE is offered throughout the year on an appointment basis, usually on Saturdays. Until otherwise announced the HATPE will be administered in Albany, New York; Long Beach, California and Atlanta, Georgia. Other centers are being planned. Please note that the HATPE application procedure and schedule differ from those related to the paper and pencil examinations.

C. To schedule an appointment, the application should be accurately completed and postmarked at least 60 days prior to the desired date for taking the exam. The application should be submitted with the fee, appointment schedule, and picture, as described in the application packet. Candidates will be assigned to Group I beginning at 7:45 a.m. or Group II beginning at 8:45 a.m. Along with the application, candidates will receive an appointment schedule on which appears the first, second, and third choices of dates. Efforts will be made to accommodate this request. A letter of confirmation along with a map of the city of test administration and the hospital, will be sent approximately three weeks in advance of the scheduled test date.

D. Part II - Teaching may be waived if the designated criteria are met. Courses submitted for waiver will be reviewed on an individual basis by the BSN transcript subcommittee.

E. Fees for the examination vary according to test site, and are listed on the application form as well as in the college catalog.

F. Cancellation Fees

The candidate is encouraged to apply for the HATPE only when he/she is fully prepared to take it and is sure of keeping the appointment. Written confirmation of the appointment will be sent approximately three weeks prior to the scheduled date of the HATPE. The examination appointment should be cancelled only when absolutely necessary, and notification should be made as soon as possible by telephone, directly to a nursing advisor in the central office. Due to the nature of the examination, refunds cannot be made. Fees previously received are subject to the following policy:

1. The candidate who is unable to take the HATPE on the scheduled date and who notifies the central office no later than ten days prior to the first day of the examination may apply for another appointment without additional fees.

2. The candidate who cancels the HATPE from ten days to three days prior to the first day of the examination will be charged a fee of $50 to cover expenses. Frequently it is difficult to locate and schedule other candidates in time to fill vacant positions in the examination schedule. The additional fee of $50 must be received in order to reschedule an examination appointment.

3. The candidate who cancels the HATPE two days or less prior to the first day of the examination, or who fails to report for the examination as scheduled, will forfeit the total examination fee. This is required to meet administrative expenses that cannot be avoided on short notice. In addition to the expenses to the program, last minute cancellations leave vacancies in the test schedule and make it impossible to locate and schedule other candidates on such short notice. Therefore, in order to reschedule the examination a candidate must submit a new application and examination fee as outlined in the study guide.

III. Waiver of the Teaching Performance Examination (TPE)

Policy on Waiver of the Health Assessment Examination

A. The Nursing Faculty Committee has eliminated waiver for the Health Assessment portion of the HATPE. All candidates requesting waiver of the HAPE must have completed the coursework by August 31, 1982, and submitted the waiver application request, fee and supporting documentation by December 31, 1982. All courses submitted before December 31, 1982, will be evaluated according to the current HATPE waiver criteria (August 1980). Courses completed after August 31, 1982, will not be considered for waiver of health assessment.

B. The Teaching portion of the HATPE may still be waived by either Route A or B as specified on the HATPE waiver criteria. Copies of the HATPE waiver criteria are available from the letterhead address.

IV. Policies and Procedures for Retaking the HATPE

A. If the initial HATPE is failed, it may be taken two more times. (Read all statements below). All policies, procedures and critical elements related to the HATPE apply to initial and to repeat examinations. If Part I, Health Assessment and Part II, Teaching are both failed, then they must both be repeated during one appointment. Special appointments will be made if only one part of the examination must be repeated.

B. When the HATPE is failed, the candidate may retake it by following the guidelines listed below:

1. A re-application may be filed after 60 days and will be considered and processed as a new application. Forms and fees must be filed at least 60 days prior to the first desired date. Therefore, except in unusual circumstances, a period of 120 days must elapse before the HATPE will be rescheduled.

2. The candidate is urged to delay taking the examination for 4-6 months to allow time for practice and to gain additional confidence and competence in health assessment and teaching.

3. Where possible, different Evaluators will be assigned for the retake examination.

C. Limitations on repeating HATPE

1. A candidate who fails the HATPE on the first attempt may repeat it no more than two times. A candidate will NOT be allowed to take the HATPE more than three times, except in highly unusual circumstances. An individual who has failed a performance examination three times may appeal to retake it a final time. This appeal must be submitted in typewritten form to the Coordinator of Nursing Programs no earlier than one year and no later than two years after the third failure of the examination.

2. A candidate will no longer be officially enrolled in the Regents External Degree Nursing Program following a lapse of two years from the date of the third failure of the HATPE (or immediately after the fourth failure if an appeal is granted). If a candidate subsequently wishes to enroll in either Regents External Degree Nursing Program, a written appeal for admission must be submitted to the Coordinator.

3. All appeals, related either to retaking the examination for a fourth time, or for readmission to the Regents External Degree Nursing Program, will be considered on an individual basis by the Overall Nursing Faculty Committee. The major factor that the Faculty will consider is documentation that additional experience has been gained through such ways as: supervised clinical experience, tutoring by

an appropriate clinical teacher, course work with health assessment and/or teaching components, and/or changes in candidates work-related activities that might provide increased expertise in history taking, physical assessment skills and/or teaching.

V. Examination Review Board

The Review Board consists of a nursing faculty committee appointed to consider the appeals made by a candidate who has failed the HATPE and who wishes to have that decision re-evaluated.

A. Composition:

Five members of the Overall Faculty Committee who have been involved in development of the program and the performance examinations will be voting members of the Review Board. The Coordinator (or designate) will be in attendance but will not have voting privileges. The Evaluator, Clinical Associate and candidate also may be consulted for clarification. The final decision rests with the Faculty Review Board.

B. Functions:

Upon receiving the candidate's typed request for appeal from the Coordinator, the Review Board shall review the results of any unsuccessful HATPE. After a thorough hearing of the case the Board's Decision shall be final, and will be communicated in writing to the candidate.

C. Procedures:

1. The candidate shall, within 30 days of the unsuccessful examination, submit, in typed form, a request for review.

2. The letter must include a detailed explanation of the circumstances pertinent to the failure of the HATPE, giving all essential facts to enable the appeal panel to understand the candidate's grievance and point of view.

3. The letter requesting the review (and any related material) shall be addressed to: Coordinator, Regents External Degrees in Nursing, Cultural Education Center, Albany, New York 12230.

4. The Review Board shall meet to review the case at the earliest convenience of its members, but no later than 90 days after the request has been received.

5. The candidate will be notified in writing of the decision of the Review Board.

VI. Preparation For The Examination

In preparing for the Health Assessment Performance Examination, candidates should think about it as an independent study course, worth 6 semester credits. The HAPE incorporates the theory related to history taking, physical examination and organization of a summary of data as well as the specific technical skills involved in the physical examination. In addition, the candidate is tested on the ability to identify and describe simulated heart and breath sounds. Candidates should be knowledgeable in all of these areas, prepared to take and record history, and perform and record a physical examination on a generally healthy client. The information gained from the history and physical will aid the candidate to identify health maintenance problems. The candidate will organize the data in order to develop a plan for nursing action. The HAPE is equivalent to the final examination of a college course in theory and practice of health assessment. Candidates are likely to be more successful in the HAPE if they already have mastered the content tested in the five nursing theory examinations. The following ideas are suggested to help the candidate plan a program of self-directed study:

A. The candidate is urged to review this entire study guide carefully and thoughtfully. The candidate should pay particular attention to the critical elements required for each area, as they are the standard against which all candidates will be evaluated while performing the health assessment and teaching examination.

B. Suggested references and study materials are listed in the attached bibliography. Candidates should review these and other references according to their particular needs, experience and background. This examination is designed to test competence in health assessment and teaching at the beginning BSN graduate level.

C. Printed references and audio-visual materials covering HATPE topics may be available in college libraries (especially where there is a nursing program), public libraries, or hospital libraries and/or in-service education units. Other health-related community agencies also may have these or similar materials and may make them available on special request. Be sure to look for and use continuing education offerings as a means of learning nursing theory and practice.

D. The study guide also includes a section which illustrates and describes requirements for each area to be tested. A sample Health Assessment record is included along with a blank form. The candidate is urged to use this form during practice sessions prior to taking the exam.

E. Suggested ways to prepare: Since each candidate has a different background and experience in nursing, different kinds of preparation are required. Several suggestions are made here but each individual must decide the course of action that is most suitable, given his/her particular situation. Not all of the suggestions will be appropriate or available to everyone, but these ideas may suggest other possibilities.

Combine several of these suggestions in the manner most appropriate to your own needs.

1. One of the most helpful activities in preparing for the HATPE is to gain employment in a setting where these skills are practiced. The daily work experience and the assistance of role models in the setting provide the opportunity to integrate theory and practice as they relate to the objectives of the Program and the HATPE. Many nurses and others in the setting are responsive to questions and expressed interest in learning. Candidates always should be alert for opportunities to relate nursing theory to practice, and to improve competence. For this examination the practice focus should be on comprehensive health assessment and health care teaching, both from the perspective of the professional nurse graduate.

2. Continuing education courses, seminars or workshops can be most helpful, in preparing to take this examination especially those related to various aspects of health assessment, interviewing, conducting physical examination, analyzing subjective and objective data, discriminating normal and abnormal heart and breath sounds and teaching. Many community colleges and universities offer continuing education courses that may provide useful information or practice sessions for the Regents External Degree Nursing candidate. District and state nurses associations and specialty nursing organizations also may provide such courses. Continuing education programs are listed in most nursing journals and posted on bulletin boards of health agencies or nursing education departments.

3. The candidate is expected to arrange opportunities to practice conducting health assessment under the supervision of a qualified nurse practitioner, physician, physician assistant, or other persons. Validation of findings is an important aspect of learning the essential skills.

4. The candidate is expected to arrange opportunities to plan and teach clients some aspect of health care and maintenance. The critical elements provide a guide to the expected behaviors to be learned. Even though the areas of a physical exam may be performed in an integrated way, the candidate is urged to practice doing each area as a separate entity to be sure to cover all critical elements as specified in the HATPE Study Guide.

5. Every effort should be made to consistently correlate skills and practice with content from textbooks and other study materials. The HATPE tests the ability to use knowledge, make decisions and apply health assessment and teaching skills in client care.

6. The candidate is reminded to proceed with the physical examination in an orderly manner (Inspection, Percussion, Palpation and Auscultation; except for the area of the abdomen, where auscultation is done after inspection).

7. The examination requires both the application of theory and competence in performance of health assessment and teaching. It is not necessary to actually memorize critical elements verbatim. However, the critical elements must be incorporated into behavior to the extent that candidates unconsciously perform all the critical elements of each area without wasting time actually thinking about them during the examination. Repeated practice, with critical elements in hand, followed by validation by a competent nurse, physician or other qualified person is strongly recommended. Such practice may also help to reduce the natural anxiety that results from continuous observation by the evaluator.

8. The candidate is urged to take time to adequately prepare. The HATPE is a comprehensive and detailed test of ability to perform a health assessment according to the standards outlined in this study guide. Exceptions will NOT be made. All of the rules of procedures outlined in this study guide will apply. Self confidence and clinical ability are very important. The candidate must realize in advance that ALL critical elements must be met with 100% accuracy, as outlined in this study guide.

9. Both components of the HATPE require knowledge of process and content related to a broad spectrum of client health care problems and nursing responses.

VII. Criteria for Passing the HATPE:

A. Part I - Health Assessment Examination (Section A)

The considerations included in the overriding areas of concern of physical jeopardy, emotional jeopardy, asepsis, interpersonal relations and clinical decision making must be maintained at all times. One violation in any of these areas will result in failure of the entire exam.

1. Phase I - Client's Health History:

   a. The candidate must meet all of the specified critical elements in the following sections:

      I - Demographic Data
      II - Reason for Contact
      III - Explanation of Current Health Status
            A) Perception of Health
            B) Analysis of Symptom
            C) Activities of Daily Living
      IV - Review of Systems

b. The candidate must meet all of the specified critical elements in 2 of the 3 remaining sections:

III - Explanation of Current Health Status
D) Personal Social/History
E) Environment
IV - History of Past - Health Illness
V - History of Family - Health Illness

c. A maximum of 80 minutes is allowed for taking the health history.

2. Phase II - Physical Examination

a. The candidate must meet all of the specified critical elements in 3 of the 4 required areas:

I - General Survey
V - Chest and Lungs
VII - Heart
VIII - Abdomen

b. The candidate must meet all of the specified critical elements in 1 of the 2 selected areas:

II - Head and Neck
III - Eyes
IV - Ears, Nose and Sinuses, Mouth and Pharynx
VI - Breasts
IX - Cranial Nerves
X - Reflexes
XI - Sensory and Motor Status
XII - Back and Extremities

c. A maximum of 60 minutes is allowed for the physical examination.

3. Phase III - Summary and Recommendations

a. The candidate must meet all of the specified critical elements related to the recording of data.
b. The candidate must meet all of the specified critical elements for analysis and summary of the data.
c. A maximum of 80 minutes is allowed for writing the summary and Recommendations.

4. Phase IV - Simulation of Heart and Breath Sounds (Section B)

a. Heart Sounds: The candidate must meet all of the specified critical elements for 3 of the 6 sounds on the audiotape.
b. Breath Sounds: The candidate must meet all of the specified critical elements for 3 of the 5 sounds on the audiotape.
c. To pass Phase IV, a total of 7 of the 11 recorded heart and breath sounds must be identified with 100% accuracy, which must include the minimum number stated in a. and b. above.
d. A maximum of 30 minutes is allowed for this portion of the examination.

B. Part II - Teaching Performance Examination (TPE)

1. To pass the Teaching Performance Examination (TPE) the candidate must meet all of the specified critical elements for each part of the test:

   a. Assessment and Planning
   b. Implementation
   c. Evaluation

2. A maximum of 60 minutes is allowed for the TPE, using the following guidelines:

   a. A maximum of 15 minutes is allowed to interview the client and assess the learning need.
   b. A maximum of 15 minutes is allowed to implement the teaching plan (actually teach the client).
   c. The remaining time (30 minutes) may be used for planning and evaluation as needed. (Suggested guide: a maximum of 20 minutes for planning and 10 minutes for evaluation).

C. Summary of time allocations for the HATPE:

1.	History	80 minutes
2.	Physical Examination	60 minutes
3.	Summary	80 minutes
4.	Heart and Breath Sound Simulation	30 minutes
5.	Teaching	60 minutes
		310 minutes (approximately 5 hours, 15 minutes)

NOTE: Failure may result if the various parts of the HATPE are not completed within the above time limits

VIII. Time Schedule for HATPE:

a. Schedule for Group I Candidates:

7:45 Arrival Time for Candidate & Clients

8:00 - 8:15	Orient to Teaching
8:15 - 9:15	Teaching Exam
9:15 - 9:45	Orient to HA & coffee
9:45 -11:05	History Phase
11:05 -12:05	Physical Exam
12:05 - 1:25	Summary Phase
1:30 - 2:00	Lunch
2:00 - 2:30	Tapes

b. Schedule for Group II Candidates:

8:45 Arrival Time for Candidate & Client

9:00	- 9:15	Orient to Teaching
9:15	- 10:15	Teaching Exam
10:15	- 10:45	Orient HA & coffee
10:45	- 12:05	History Phase
12:05	- 1:05	Physical Exam
1:05	- 2:25	Summary Phase
2:30	- 3:00	Lunch
3:00	- 3:30	Tapes

IX. Frequent Reasons for Failure of HATPE: The candidate is urged to think about the following examples of problems that other candidates have encountered. These errors or omissions are violations of established critical elements and therefore are grounds for failure. The candidate is responsible for studying and learning all of the specified critical elements and for demonstrating competence in all of them during the examination.

A. Health Assessment:

1. Inaccurate recording of pulse, respiration, blood pressure. Take each twice before recording results on the examination form.

2. Failure to balance the scale prior to weighting the client, as specified by the critical elements.

3. Omission of one or more critical elements. Every critical element must be met.

4. Omission of one aspect of a critical element, e.g., omission of testing for each reflex as specified in the critical element.

5. Failure to listen to the four valvular areas of the heart with <u>both</u> the bell and the diaphragm of the stethoscope.

6. Neglecting to record the absence of, or negative findings, as well as the positive findings; critical elements for recording data require both, in order to document findings.

7. Neglecting to properly identify self when greeting the client at the beginning of the test.

8. Violation of asepsis: for example:
   a) Failure to wash hands prior to the physical exam.
   b) Neglecting to clean the ear pieces of the stethoscope after use.
   c) Neglecting to maintain asepsis of the scale.
   d) Neglecting to clean the ear/nose speculum after use.

B. Teaching:

1. Failure to write a behavioral learning objective in measurable terms.

2. Failure to state a client-centered objective which is attainable within the 15 minute actual teaching session.

3. Failure to ask at least one question to determine client's understanding. (Questions eliciting one word answers are unacceptable, e.g., questions able to be answered with "yes" or "no").

4. Use of inappropriate language. This includes vocabulary which is beyond the client's level of understanding, as well as any language which is abusive, threatening, offensive or unprofessional.

5. Failure to state the outcome of the teaching-learning episode in relation to the objective stated in the planning phase. The critical element of the evaluation phase is important in passing this examination as it shows culmination of the nursing process.

C. General Reasons:

1. The candidate terminates the examination before its completion, regardless of the reason.

2. The candidate exceeds the time limits (see page 14 of the study guide for summary of time allocations).

3. The candidate exhibits behavior that actually or potentially jeopardizes clients or evaluators or behavior that discredits the Regents External Degree Program in the test center.

X. General Points of Information

A. Setting - The Health Assessment and Teaching Performance Examiation usually is administered in an actual clinic setting. There are individual, private examining rooms where all the phases of Part I and Part II of the HATPE will be conducted. The candidate will receive an orientation to the clinic area prior to beginning the exam.

B. Clients - For purposes of this examination the "clients" are individuals from the community who are selected and oriented to assume the role of client. They are not actual patient/clients. They know that the candidate is taking this exam as part of the degree requirements. Clients have been instructed neither to withhold nor to volunteer information in an unnatural way. They are programmed to respond as indicated to the questions asked by the candidate.

C. Evaluators - Evaluators are nurse educators/practitioners with special preparation in health assessment. They have been oriented to function as neutral observers of the candidate's performance during the exam, using the specified critical elements. Evaluators do not teach, coach or give feedback, nor do they ask questions for clarification. They are present to document that the candidate does or does not perform all of the critical elements.

Criteria for Selection of HATPE Evaluators

The Evaluator must:

1. Possess a masters degree with a major in nursing.
2. Have taught in a baccalaureate program for three of the past five years.
3. Have experience in teaching health assessment or practice doing assessment, or preparation in either teaching or practice in the last three years. (To be evaluated individually).
4. Hold a valid license to practice as a Registered Nurse.
5. Currently hold proof of professional liability insurance.

Conditions to Minimize Evaluator Bias

1. The candidate's performance on health assessment will be assessed by one Evaluator and another Evaluator will assess teaching.
2. Candidates must withhold personal information, and Evaluators are forbidden to ask personal questions pertaining to the candidate's background, residence, current employment, etc., until after the entire examination has been concluded.
3. An Evaluator who thinks he or she us unable to render an objective evaluation of a particular candidate will not engage in the evaluation of that candidate. If the candidate has a justifiable reason to believe that an Evaluator is biased, another Evaluator may be requested. The Clinical Associate will make changes in Evaluator assignment as necessary.

D. Clinical Associate - The Clinical Associate is a nurse educator with special preparation in health assessment who coordinates the administration of the exam. The candidate may ask questions or verbalize problems/concerns to the Associate. The Associate is the only one who knows the backgrounds of the candidates. She will provide an orientation for each phase of the exam. The Associate assists Evaluators in expediting the examination and is available to Evaluators for consultation.

E. Examination Process

1. Along with the letter of confirmation regarding the examination appointment, the candidate will receive information about travel and lodgings, and directions (with map) to the test center.

2. The candidate must bring the duplicate photograph to be attached to the application and a ballpoint pen with blue or black ink. Candidates may also bring and use personal physical assessment equipment. This is not necessary as equipment is provided for each candidate on the day of the examination.

3. Candidates will receive a detailed orientation prior to each part of the HATPE, and be allowed to ask questions to clarify test procedures. No instructions related to health assessment or teaching skills will be provided.

4. At the beginning of the Teaching part of the examination, candidates will choose a card on which will appear the number of an examining room. The Evaluator assigned to that room will give the candidate a card with the client's name and area for health teaching. The client has already been seen by a medical doctor and referred to the clinic. The candidate shall be allowed 5 minutes to organize thoughs prior to interviewing the client to determine the specific teaching need included in the general area of health need that was indicated on the card. The client will go the client's waiting room while the candidate remains in the examining room to organize and write the teaching plan. The Evaluator will be present during the initial interview and during the actual teaching episode. These two areas also will be tape recorded in case validation is needed by the Evaluator during the grading of the examination or by the Review Committee during the appeal process.

5. At the beginning of the Health Assessment Examination, the candidate will move to a different examining room. The Evaluator assigned to the room will hand the candidate the recording form, on which will be the client's name. The examination begins immediately when this form is received. The candidate will then go to the client's waiting room, call the client's name and proceed to the examining room to begin the history. The Evaluator will not be present during the history phase, but the entire history phase will be tape recorded. The tape recording is used if the evaluator notes a discrepancy between the candidate's recording of the history and the client's baseline history. The tape recording is also available for validation by the Review Committee during the appeal process.

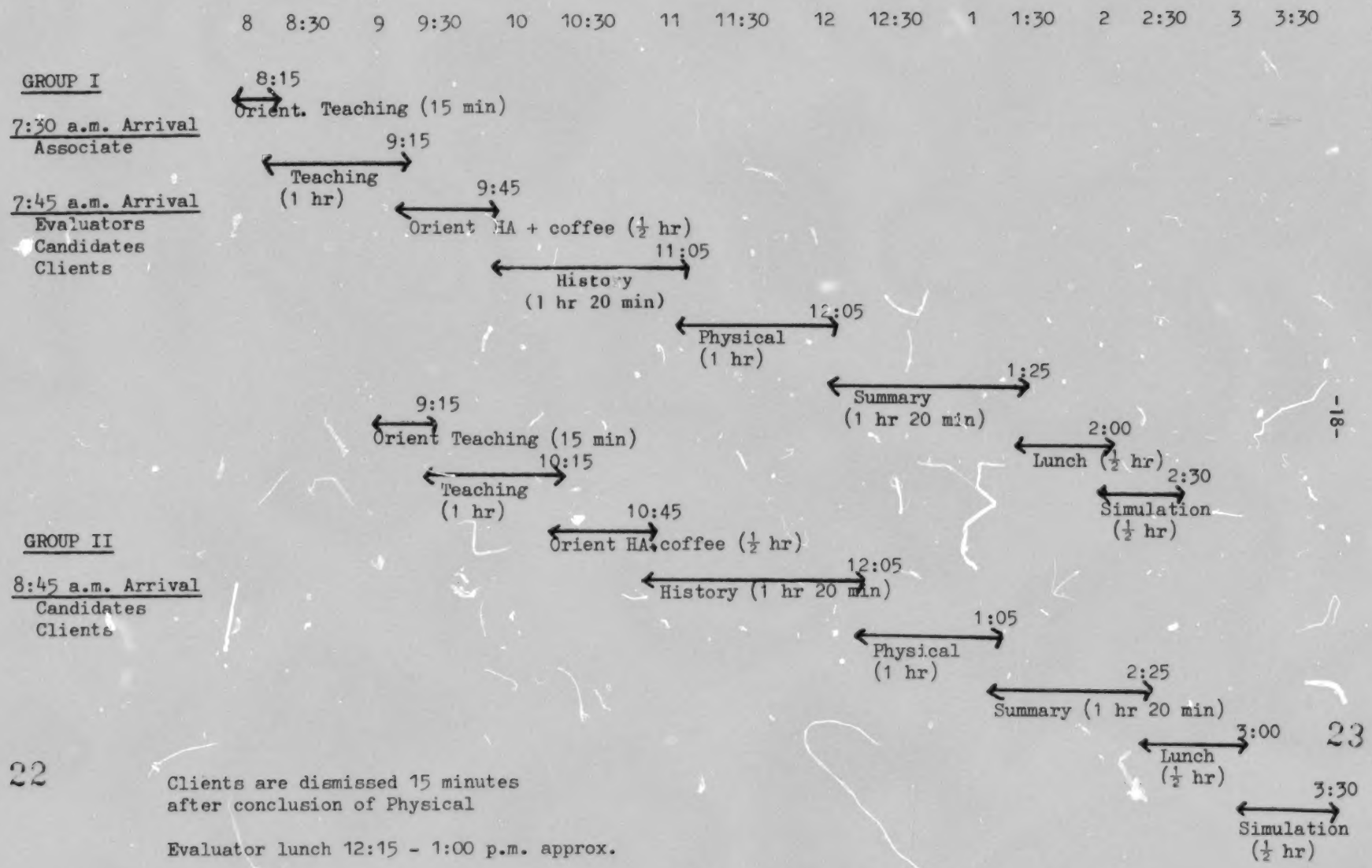
6. The selected areas that will be tested have been predetermined for each client. Prior to beginning the physical examination, the candidate will be told which two selected areas must be completed.

7. Candidates will receive an orientation to the simulated Heart and Breath sounds test. Then each candidate will be seated in an examining room with a tape recorder and a stethoscope.

8. The results of the examination will be mailed to each candidate within two (2) weeks of the test date.

9. The next page is a Flow Chart for the entire HATPE to give candidates an idea of the schedule of events during the day and how the two groups of candidates will be accommodated.

HATPE FLOW CHART



22

Clients are dismissed 15 minutes after conclusion of Physical

Evaluator lunch 12:15 - 1:00 p.m. approx.

23

PART I

HEALTH ASSESSMENT PERFORMANCE EXAMINATION

SECTION A

PROPERTY OF THE REGENTS EXTERNAL DEGREE PROGRAM

DO NOT REPRODUCE

PART I - HEALTH ASSESSMENT PERFORMANCE EXAMINATION

CRITICAL ELEMENTS

READ CAREFULLY

I. Recording the Findings:

1. Performance and recording of all critical elements for the history and physical exam are both equally essential. Omission of either the performance or the recording of one critical element is grounds for failure of the area being tested.

2. A response must be written on the Recording from to every critical element, (and to each part of a critical element when indicated), for both the history and the physical exam.

3. The candidate must explore and record findings indicating both the presence and the absence or required data, the positive and the negative findings, to document that they have explored the assigned areas as required. Evaluators cannot know what has been inspected or observed, or discovered unless the findings are recorded on the form.

4. The candidate is expected to use objective, precise, but descriptive language, as illustrated in the Study Guide and in the references; only those abbreviations and symbols that are specified in the Study Guide may be used.

5. The candidate must write in clear, legible script when recording data, using blue or black ink. Evaluators cannot make accurate decisions about the candidate's competence if the record is illegible.

II. Overriding Areas of Concern:

1. PHYSICAL JEOPARDY

Definition: Any action or inaction on the part of the candidate which threatens the client's physical well-being.

Critical Elements:

1. There are no specific critical elements, but failure must be substantiated by the Evaluator and confirmed by the Clinical Associate.

2. ASEPSIS

Definition: The prevention of the introduction and/or transfer of organisms.

Critical Elements:

1. Washes hands in the presence of the Evaluator prior to beginning the physical examination.
2. Protects self from contamination.
3. Protests the client from contamination.

3. EMOTIONAL JEOPARDY

Definition: Any action or inaction on the part of the candidate which threatens the client's emotional well-being.

Critical Elements:

1. There are no specific critical elements, but failure must be substantiated by the Evaluator and confirmed by the Clinical Associate.

4. INTERPERSONAL RELATIONS

Definition: Relating with others is behaving in a manner that facilitates the achievement of client-oriented goals and that is consistent with principles of interpersonal relations. It is the manner in which the candidates uses and responds to verbal and nonverbal behavior in gathering information, clarifying meaning, imparting knowledge, encouraging behavior change, listening and involving the other in making decisions. Competence in relating with others will be evaluated throughout the examination.

Critical Elements:

1. Introduces self to client at the beginning of the examination.
2. Describes to client in advance those aspects of the physical examination that may be uncomfortable.
3. Asks at least 1 question to determine whether or not procedures cause discomfort.

5. CLINICAL DECISION-MAKING

Definition: Clinical Decision-Making is a process by which choices are made within the context of nursing and health care problems. The competencies include obtaining data, integrating knowledge, analyzing information, making the choice from among available options and giving rationale.

The candidate will be evaluated on clinical decision-making throughout the entire examination. The ability to make decisions spontaneously as well as after deliberation will be measured in response to the situation.

Critical Elements:

1. Identifies the options that are potential solutions to the problem situation.
2. Selects the option that is:
   a. Legal
   b. Consistent with the data presented in the situation
   c. Consistent with the client's value system
   d. Consistent with client-oriented goals
3. Makes a decision based on a rationale that is:
   a. Logical (reasonable, based on earlier statements or events, showing consistency of logic)

      Or

   b. Based on scientific principles

      Or

   c. Based on published literature
4. Changes decision only when dictated by new relevant data, or further analysis of existing data.

NOTE: Failure of any one of the preceding five Overriding Areas of Concern is grounds for failure.

Phase I: Client's Health History

I. DEMOGRAPHIC DATA

Definition: Demographic Data includes basic information that identifies the client and that may have implications for the individual's health status.

Critical Elements:

1. Records data for each demographic area listed on the form.

II. REASON FOR CONTACT

Definition: The reason for contact is a succinct phrase that identifies the particular reason the client is seeking assistance.

Critical Elements:

1. Records reason for client's visit in client's own words.

III. THE EXPLORATION OF CURRENT HEALTH STATUS

Definition: The exploration of current health is a comprehensive description of the multiple components of the current health status including the client's perception, an analysis of a symptom (if present), activities of daily living, personal-social history and environment.

Critical Elements:

A. Perception of Health

1. Describes in general terms, the client's perception of his/her own current health status.

2. Records any health concern or symptom identified by the client, using client's own words.

B. Analysis of Symptom, if Present

1. Describes onset of symptom including at least 2 of the following factors:

a. Length of time since onset, noting either the approximate date of onset or length of time since onset.

b. Whether onset of the symptom was abrupt or gradual.

c. Presence of 1 or more precipitating factors recalled by client or notes absence of such factors.

2. Describes characteristics of symptom including at least 3 of the following factors:

a. Type, quality, and/or consistency of symptom.

b. Extent and location of symptom using anatomical terms: i.e. regions, landmarks, or lines of reference, etc.

c. Temporal aspect of the symptom, i.e., intermittent or continuous, duration, relationship to other symptoms, bodily functions or activities.

d. Intensity or severity of the symptom, as it affects the client's ability to perform usual activities of daily living.

e. Presence or absence of one or more commonly associated signs and/or symptoms.

3. Describes course of symptom since onset including at least 2 of the following factors:

a. Whether symptom is improved, worsened or unchanged since onset.

b. Presence or absence of medications and/or treatments being used to relieve symptom, whether self- or medically prescribed.

c. Client's perception of whether or not these medications and/or treatments relieve the symptom.

C. Activities of Daily Living

1. Describes pattern of nutrition by listing a typical 24 hour intake of food and fluid.

2. Describes usual patterns of sleep and exercise.

3. Records usual pattern of bowel elimination.

4. Records type and patterns of work and recreation.

5. Describes use of tobacco, including such factors as type, amount and historical pattern of use.

6. Describes use of mood affecting drugs such as alcohol, marijuana, stimulants, depressants, narcotics, etc.

7. Records client's satisfaction or concerns related to the above activities of daily living.

D. Personal/Social History

1. Describes client's feelings about his/her interactions with significant others such as: parents, spouse/living partner, children, co-workers, friends.

2. Describes client's feelings about self such as: current life style, usual pattern of adaptation to stress, usual mood, strengths and weaknesses.

E. Environment

1. Describes at least 2 characteristics of physical conditions of client's home, work or school environment.

2. Records access to or problems with transportation.

3. Describes at least 2 characteristics of client's community such as: relative size, socio-economic status, availability of human services/resources, environmental hazards.

4. Records client's perception of economic adequacy to meet living expenses.

IV. HISTORY OF PAST HEALTH-ILLNESS

Definition: History of past health is the in-depth exploration of client's past illnesses, immunizations and use of medications.

1. Records history of communicable diseases listed on recording form.

2. Records history of immunizations listed on recording form.

3. Records result for last tuberculin test.

4. Records approximate date for last tetanus injection.

5. Records presence or absence of allergy(ies) to substances listed on form.

6. Describes type of allergic reaction(s) and related treatment, if relevant.

7. Records history of major physical and emotional illness(es); including such factors as age of occurrence and presence of sequelae.

8. Records major surgical procedures, including such factors as age of occurrence and presence of sequelae.

9. Records major accidents and/or injuries including such factors as age at occurrence and presence of sequelae.

10. Records any prescribed and/or nonprescribed medications routinely used, noting such factors as frequency and reason for use.

V. HISTORY OF FAMILY HEALTH-ILLNESS

Definition: History of Family Health-Illness is an exploration of the health status and disease history of each member of the client's immediate family and the presence of illnesses with genetic tendencies among members of the extended family.

Critical Elements:

1. Records health status for parents and at least 1 other category of immediate family members indicating age, presence of disease, cause of death if deceased and age at death. (Immediate family includes: parents, children, siblings, spouse/living partner.)

2. Records the presence or absence of at least 3 diseases with genetic tendencies among members of the extended family.

VI. REVIEW OF SYSTEMS

Definition: The review of systems is a comprehensive account of the past and present status of each body system, obtained by direct questioning during the history phase. This systematic fact-finding review prevents the omission of significant subjective data that relates to the present health status and otherwise may have been overlooked.

Critical Elements:

1. Records, as a minimum, the presence or absence of the specific symptoms and/or conditions (past and present) listed on the form for each body system.

2. Records at least 2 factors related to onset, characteristics, or course since onset for 2 of the positive findings identified in the Review of Systems.

VI. Review of Systems

A. General State of Health:
- General well-being
- Recent changes in weight
- Other

B. Integumentary System:
- Eruptions/Lesions
- Pruritus
- Other

C. Head:
- Headaches
- Trauma to head
- Other

D. Eyes:
- Date of last eye examination
- Disturbances in vision
- Other

E. Ears:
- Recurrent infections
- Disturbances in hearing
- Other

F. Nose and Sinuses:
- Pain
- Discharges and/or post nasal drip
- Obstruction
- Epistaxis
- Other

G. Mouth and Throat:
- Date of last dental exam
- Recurrent sore throat or tonsilitis
- Hoarseness or change in voice
- Pain, soreness or lesions
- Disturbances in chewing and/or swallowing
- Other

H. Respiratory:
- Coughing
- Wheezing
- Shortness of breath
- Pain
- Other

I. Cardiovascular:
- Chest pain
- Shortness of breath
- Edema
- Hypertension/Hypotension
- Heart Murmur
- Disturbances in cardiac rate or rhythm
- Other

J. Gastrointestinal:
- Appetite changes
- Disturbances in digestion
- Jaundice
- Changes in bowel habits
- Constipation/Diarrhea
- Blood in stool
- Other

K. Genito-Urinary:
- Hematuria
- Kidney or bladder problems
- Nocturia
- Venereal disease
- Impotency
- Disturbances in urination
- Other

L. Endocrine:
- Polyuria
- Polydipsia
- Polyphagia
- Thyroid Problems
- Other

M. Hematopoietic:
- Bruising
- Anemia
- Enlarged glands
- Other

N. Musculoskeletal:
Disturbances in muscles and/or joints
Other

O. Neurological:
Seizures
Memory loss
Paralysis
Sensory disturbances
Vertigo
Tremors
Syncope
Other

P. Gynecology:
Contraception
Dyspareunia
Venereal disease
Breast problems
Vaginal discharges

Date of last pap smear _____

Menstrual History:

Age at onset _____ Duration _____
Frequency _____
Age, at onset of menopause_____

Obstetrical History:

No. of pregnancies ____ No. of deliveries ____
No. of abortions ____ No. of living children ____

Other

Phase II: Physical Examination

I. General Survey

NOTE: Under each heading, the first statement is the definition of that category. This is followed by a list of the critical elements that must be satisfied.

A concise statement of the candidate's general impression of the physical and mental status of the client. This includes a general description of the client's level of wellness, overall appearance, physical and mental condition and vital signs.

1. Writes at least one general statement using objective characteristics to describe the physical status of the client.

2. Writes at least one general statement using objective characteristics to describe emotional status of the client.

3. Writes one general statement using objective terms describing the general condition of the skin.

4. Records vital signs as indicated on form.

   a. When measured by an instrument:

      1. Places the instrument at the proper location
      2. Reads the instrument within a range of:

         ..$\pm$ 6 millimeters for blood pressure

   b. When measured without an instrument:

      ..$\pm$ 2 respirations/minute for respiration
      ..$\pm$ 5 beats/minute for pulse

   c. Weight

      1. Balances scale before weighing client
      2. Reads scale within a range of:

         ..$\pm$ 2 lb or 1 kg

   d. Height

      1. Places head level marker firmly against top of head.
      2. Reads height within $\pm$ ½" or 1 cm.

II. Head and Neck

An examination of the external structure of the head. An examination of the neck including mobility, size and placement of internal structure, and presence of lymphadenopathy.

1. Inspects for obvious abnormalities of the face.

2. Palpates skull surfaces for normal and/or abnormal findings in bony or soft tissue.

3. Palpates for pulsations over carotid arteries comparing quality, bilaterally.

4. Palpates anterior and posterior lymphatic chains in neck using palmar surface of fingertips and rotary motion.

5. Palpates neck for position of trachea.

6. Palpates for enlargement of thyroid gland using one of 2 approved techniques.

7. Records data required by the above critical elements including positive and negative findings.

III. Eyes

An examination of the external structure and function of both eyes.

1. Uses Snellen Chart to determine visual acuity (using glasses if glasses are worn).

2. Tests near vision by using Snellen Near Vision chart or newsprint.

3. Inspects eyes and external structures surrounding eyes for abnormalities.

4. Tests extraocular movement by having client follow finger through the 6 cardinal fields of vision.

5. Inspects for convergence.

6. Tests peripheral vision by using confrontation technique.

7. Inspects alignment of eyes for strabismus.

8. Inspects for pupillary reaction to light.

9. Inspects for the red reflex using ophthalmoscope.

10. Records data required by the above critical elements including positive and negative findings.

IV. Ears, Nose & Sinuses, Mouth & Pharynx

1. Determines gross hearing by using whisper or watch test.

2. Inspects external structures of the ears for abnormalities.

3. Inspects each ear canal for abnormalities using otoscope, without causing unnecessary discomfort to client.

4. Inspects each tympanic membrane for presence of landmarks.

5. Inspects for patency of nose.

6. Inspects membranes of nares for discharge.

7. Palpates or percusses for tenderness over frontal and maxillary sinuses.

8. Inspects for presence or absence of lesions and signs of inflammation for 3 of the following areas:

   a. Gums
   b. Superior and inferior surfaces of the tongue
   c. Buccal mucosa
   d. Pharynx
   e. Tonsils

9. Inspects for presnece or absence and condition of teeth using a direct source of light.

10. Records data required by the above critical elements including positive and negative findings.

V. Chest and Lungs

An examination of the external structures of chest and the function of the lungs.

1. Inspects for abnormalities of the bony structures of both the anterior and posterior chest noting presence or absence of kyphosis, scoliosis and any other gross deviations.

2. Inspects for presence or absence of alterations in anterior-posterior diameter noting barrel chest, if present.

3. Palpates for symmetry of respiratory excursion by placing hands on back at the inferior border of the rib cage with thumbs proximal to spinal column.

4. Palpates posterior chest wall for tactile fremitus comparing lung fields.

5. Percusses posterior chest wall bilaterally using mediate percussion technique.

6. Auscultates breath sounds over each lobe of both lungs moving the stethoscope systematically from side to side and top to bottom, over all three surfaces: anterior, lateral, and posterior surfaces.

7. Describes adventitious respiratory sounds if present.

8. Records data required by the critical elements including positive and negative findings.

VI. Breasts

An examination of both breasts and axilla in female clients.

1. Inspects breast for shape and symmetry with the client in an upright position.

2. Inspects nipples for discharge and retraction with the client in an upright position.

3. Inspects breasts for dimpling and retraction while client performs at least 1 of 3 accepted maneuvers.

4. Palpates both breasts and axilla systematically for masses and tenderness, using palmar surface of fingers and using a technique of examination that can be documented in 1 of the major references.

5. Records data required by the above critical elements including positive and negative findings.

VII. Heart

An examination of selected cardiac function.

1. Inspects anterior chest wall for presence or absence of pulsations or heaves.

2. Palpates anterior chest wall to locate point of maximum intensity (P.M.I.) and if identifiable, notes anatomical location.

3. Listens to cardiac sounds over the 4 valvular areas using both the bell and diaphragm of the stethoscope for each area.

4. Listens to heart beat noting rhythm.

5. Describes grossly abnormal cardiac sounds, if present.

6. Records data required by the above critical elements including positive and negative findings.

VIII. Abdomen

An examination of the abdomen, including the assessment of external structures, the size and position of the liver and the presence of gross abnormalities in the abdominal area.

1. Inspects abdomen for contour and lesions (including surgical scars).

2. Listens for the presence of bowel sounds using a stethoscope.

3. Percusses all 4 quadrants of abdomen using mediate percussion technique.

4. Performs deep palpation to identify the inferior borders of the liver while client takes deep breaths.

5. Performs light palpation over the 4 quadrants to determine the presence and location of tenderness and/or masses.

6. Records data required by the above critical elements including positive and negative findings.

IX. Cranial Nerves

An examination of the gross function and/or dysfunction of the cranial nerves.

1. Examines systematically all 12 cranial nerves testing at least 1 sensory or motor function to determine presence or absence of normal function for a minimum of 9 of them.

2. Records data required by the above critical elements including positive and negative findings.

X. Reflexes

An evaluation of the required deep tendon reflexes (including biceps, triceps, patella and achilles) and the plantar reflexes bilaterally.

1. Stimulates the required deep tendons bilaterally to elicit a response using a reflex hammer.

2. Stimulates the plantar reflexes bilaterally.

3. Records on the stick figure an estimate of each tendon response elicited for the respective site using a scale of 0-4, and records plantar response.

XI. Sensory and Motor Status

An examination of the gross function and/or dysfunction of the sensory and motor systems.

1. Observes bilateral responses to light touch and painful stimuli on distal portion of extremities.

2. Observes for strength in lower extremities while having client perform shallow knee bend.

3. Observes for strength of upper extremities by testing hand grip bilaterally.

4. Observes muscle tone in extremities while passively moving extremities through range of motion.

5. Observes for abnormalities in gait while having client walk.

6. Records data required by the above critical elements including positive and negative findings.

XII. Back and Extremities

An examination of the structure and function of the muscles, bones and joints of the back and extremities.

1. Directs client to move neck through its range of motion.

2. Inspects back for structural changes of spine (including contour, and presence of kyphosis or scoliosis.)

3. Inspects the spine while client is bending forward, describing observed function and structure.

4. Palpates spinal column to determine presence or absence of tenderness.

5. Inspects joints of extremities noting enlargement and/or deformity: including shoulders, hips, elbows, wrists, fingers, knees and ankles.

6. Palpates major joints of extremities noting tenderness: including shoulders, hips, elbows, wrists, fingers, knees and ankles.

7. Inspects muscles of extremities noting symmetry.

8. Directs client to move 4 of the major joints through range of motion, bilaterally, noting function. This must include shoulders and hips and any 2 of the other major joints (elbows, wrists, hands, knees, ankles).

9. Records a summary of positive and negative findings elicited by the critical elements above describing specific deviations from normal structures and functions by the above critical elements.

XIII. Circulatory Status of Extremities

An examination of the circulatory status of the upper and lower extremities, bilaterally.

1. Inspects distal portions of extremities for circulatory status describing at least 2 characteristics such as: color, temperature, pigmentation, texture.

2. Palpates for edema by pressing over ankle or shin and observing for pitting.

3. Palpates radial, femoral and dorsalis pedis pulses bilaterally to determine their presence and relative strength, or absence.

4. Records data required by the above critical elements including positive and negative findings.

Phase III - Summary

NOTE: These are general guidelines to be used in completing and evaluating this phase.

A. Data Recording

1. Records subjective and objective data gathered during history and physical examination in designated categories on the form provided.

B. Problem Statements

1. Identifies two actual or potential problems based on the data collected during the history and physical examination.

2. Writes a problem-oriented analysis (SOAP format) for one of the problems identified above including comments in the following categories:

a) Subjective data related to the health problem.

b) Objective data related to the health problem.

c) Assessment of the data related to the health problem including such factors as the nature of the problem and its impact on daily living.

d) A nursing plan that reflects consideration of such factors as:

Data obtained, additional data to be obtained, nursing treatment, client teaching, referral/ consultation.

HEALTH ASSESSMENT PERFORMANCE EXAMINATION

Explanation and Suggested Learning Activities

PHASE I - HEALTH HISTORY

12/81

CRITICAL ELEMENTS	EXPLANATION	RESOURCES/LEARNING ACTIVITIES
I. Demographic Data 1. Records data for each demographic area listed on the form.	I. Candidate will introduce self to client. Demographic data will appear on the Recording Form. Candidate should complete any missing data.	See "Jane Doe" and "Mary Smith" samples.
II. Reason For Contact 1. Records reason for client's visit in client's own words.	II. Client may report the need for a general physical, or relate a specific problem (chief complaint) or make a request for care. Candidate should record this in client's own words highlighting the client's major concern. This is not the appropriate place to describe or explore the details of the problem. To obtain this information, candidate might ask "what brings you here today?" Examples of recordings of client's responses are: "I need a physical for my job" "I've gained a lot of weight" "I've had frequent indigestion lately" While the client may not specify a health concern at this time, one may arise at a later time in the interview.	See references 2 or 4 and 9, also helpful, reference 6.

III. Exploration of Current Health Status	III. This area explores the client's understanding of general health status which may or may not include a health problem. This should be recorded in a brief statement. One example might be "I've always been healthy." Another way may be to say "Client stated that his general health has been good until these headaches started."	Same references as above. In addition, references 5, 6, 8, 23, 27 or 29 may be helpful for interviewing techniques.
A. Perception of Health		
1. Describes in general terms, the client's perception of own current health status.		
2. Records any health concern or symptom identified by the client, using client's own words.		
B. Analysis of Symptom, if Present.		
1. Describes onset of symptom including at least 2 of the following factors:	B1. In analyzing the symptom use open-ended questions so that the client can be encouraged to relate details and talk freely about why attention is being sought now. An example is "You said the symptom began last week. Can you tell me more about how you felt?" Consider all factors which the client feels may be related to the problem. Regardless of the sequence in which information is obtained it should be recorded in chronological order from onset to present state. It is important to note whether the symptom was abrupt or gradual, i.e., "I awoke with a sharp pain" abrupt onset. Gradual onset - "I noticed a slight ache in my stomach - It slowly moved and got stronger by the week's end."	Reference 9 is the best reference to use as guideline for writing an analysis of a symptom. Reference 6 is another good reference with a fine sample. Reference 34 is also helpful.
a. Length of time since onset, noting either the approximate date of onset or length of time since onset.		
b. Whether onset of the symptom was abrupt or gradual.		
c. Presence of one or more precipitating factors recalled by client or notes absence of such factors.		

2. Describes characteristics of symptom including at least 3 of the following factors:	2. For examples - see Reference 9	Reference 9 best reference for this entire section.
a. Type, quality, and/or consistency of symptom.		All major texts.
b. Extent and location of symptom using anatomical terms: i.e., regions, landmarks, or lines of reference, etc.		"Jane Doe" and "Mary Smith" samples.
c. Temporal aspect of the symptom, i.e., intermittent or continuous, duration, relationship to other symptoms, bodily functions or activities.		
d. Intensity or severity of the symptom, as it affects the client's ability to perform usual activities of daily living.	d. Emphasis is on the effect on the client and on the client's daily activities. For example the client stated that "the pain in my stomach caused me to stop what I was doing and lie down for awhile."	
e. Presence or absence of one or more commonly associated signs and/or symptoms.	e. Include symptoms in body regions not directly involved with the primary symptom of abdominal pain. For example: "the client denies any nausea, vomiting or diarrhea."	
3. Describes course of symptom since onset including at least 2 of the following factors:	3a. Self-explanatory.	
a. Whether symptom is improved, worsened or unchanged since onset.		
b. Presence or absence of medications and/or treatments being used to relieve symptom, whether self or medically prescribed.	3b. May need to give examples of treatment, such as, does a hot shower or household remedies relieve the spasm.	

c. Client's perception of whether or not these medications and/or treatments relieve the symptom.	c. Emphasis is on whether or not the client felt relief was achieved by the treatment. If client does not state a health problem in the reason for contact the candidate should be aware that a health concern or problem will arise during another portion of the health history such as in the Nutritional Intake or the Review of Systems. When the candidate has determined the health concern or symptom it should be identified on the recording form and analyzed in Section B, Analysis of Symptom.	
C. Activities of Daily Living		
1. Describes pattern of nutrition by listing a typical 24 hour intake of food and fluid. 2. Describes usual patterns of sleep and exercise. 3. Records usual pattern of bowel elimination. 4. Records type and patterns of work and recreation. 5. Describes use of tobacco, including such factors as type, amount and historical pattern of use.	1. List specific foods and fluids. Candidate should try to list specific amounts since servings may have different meanings to different individuals. 2-6. Candidate should be careful to avoid value judgments in questions and recorded data. Note the emphasis on "usual patterns."	Reference 2 has an excellent chapter on total nutritional assessments. Activities of daily living included in references 4 and 6. Reference 2 covers this information under the broader area of developmental assessment.

6. Describes use of mood-affecting drugs such as alcohol, marijuana, stimulants, depressants, narcotics, etc.		
7. Records client's satisfaction or concerns related to the above activities of daily living.	Explore the patterns and record client's concerns or satisfactions with ADL patterns. Note the emphasis on client's concerns or satisfaction. Do not interpret and evaluate.	
D. Personal/Social		
1. Describes client's feelings about his/her interactions with significant others such as: parents, spouse/living partner, children, co-workers, friends.	1-2. Explore and record the client's description of his/her relationships with others and feelings about self. Do not make interpretations and diagnoses, rather record the client's feelings in his/her own words. Note any discrepancies between what is being said and what is actually observed. For example, the client says she is usually cheerful but throughout the interview appears depressed. (Describe the behavior). This section is not intended to be an indepth mental status evaluation. The focus is on the types of interactions with other people and feelings about self since these may give the nurse insight into client's emotional well-being.	Reference 30 may be helpful in addition to primary texts.
2. Describes client's feelings about self such as: current life-style, usual pattern of adaptation to stress, usual mood, strengths and weaknesses.		

E. Environment		
1. Describes at least 2 characteristics of physical conditions of client's home, work or school environment.	1. Identify specific factors which relate to the physical environment of the client's home, place of work, or school such as space, number of occupants, utilities, sanitation, safety, etc. Try to elicit the presence of actual or potential hazards. Avoid value statements such as "poor" or "good" in description.	In addition to previously identified texts use public health or a community health text.
2. Records access to or problems with transportation.	2. Identify the client's usual mode of transportation such as "owns own car" or "lives near bus route" or "has a regular means of transportation, relies on friends."	
3. Describes at least 2 characteristics of client's community such as: relative size, socio-economic status, availability of human services/ resources, environmental hazards.	3. Descriptors such as urban/rural congested; upper-middle income area, close to churches, schools, shopping; safe for children; close to major highways; rundown, deteriorating neighborhood are adequate to meet the critical elements.	
4. Records client's perception of economic adequacy to meet living expenses.	4. Client's perception of economic adequacy is the key, not the monetary amount.	
IV. History of Past Health-Illness		
A. Common Communicable Diseases		
1. Records history of communicable diseases listed on recording form.	1. If client has had any of the diseases, it is important to ascertain and record if there have been any long-term or chronic residual effects. If	This material is covered in all of the primary references.

	client doesn't remember age of occurrence it is acceptable to record: "age, unknown" or "childhood/adulthood."	
2. Records history of immunizations listed on recording form.	2. If status or dates of immunizations are unknown, it is acceptable to record "not known."	2. Review immunization standard for the health maintenace of particular age groups. (Community Health, Adult Health, or Pediatric texts).
3. Records result for last tuberculin test.	3 & 4. Critical elements are self-explanatory.	
4. Records approximate date for last tetanus injection.		
5. Records presence or absence of allergy(s) to substances listed on form.	5 & 6. Example: "Allergic to penicillin. Developed rash and joint pain following 5 days of oral penicillin."	5. See description in references 2 or 4.
6. Describes type of allergic reaction(s) and related treatment, if relevant.	"Received cortisone therapy. Is aware of importance of avoiding further penicillin therapy."	
7. Records history of major physical and emotional illness(es) including such factors as age or occurrence and presence of sequelae.	7. Major medical illnesses are those episodes which required hospitalization and/or medical interventions. Any deviations from a normal pregnancy that required medical or surgical therapies should be recorded here. Routine OB-GYN history is recorded in Review of Systems. Frequently, a client will not consider a broken bone a major occurrance unless specifically asked. It is necessary to ask the client specifically about the presence of mental illness since this is often not volunteered. It may be helpful also to use lay terminology (i.e., nervous breakdown) to elicit this information.	All of the references adequately discuss this category.

8. Records major surgical procedures, including such factors as age of occurrence and presence of sequelae.	8. Self explanatory.	See Reference 6.
9. Records major accidents and/or injuries including such factors as age of occurrence and presence of sequelae.	9. Any fracture should be included. In addition, it is sometimes helpful to ascertain <u>why</u> the accident occurred, as this might give clues to some other disorders, e.g., epilepsy.	
10. Records any prescribed and/or nonprescribed medications routinely used, noting such factors as frequency and reason for use.	10. In addition to prescription medications, it is important to ask if they take nonprescription medicines. Such questions as "what do you normally take for a headache, constipation, upset stomach or when you can't sleep" are helpful in eliciting this information. It is necessary to ask about birth control pills since clients often do not consider these medications. Record the abusive use of drugs under, Patterns of Drug, Alcohol & Tobacco use.	
V. History of Family Health Illness		
1. Records health status of parents and at least one other category of immediate family members 1 indicating age, presence of disease, cause of death if deceased and age at death. (Immediate family includes: parents, children, siblings, spouse/living partner.)	1. This may be done by chart forms or drawing a pedigree or family tree. Note that immediate family includes spouse/living partner. This section of the history gives the nurse data not only about the client's genetic history but may also provide insight into the health status of immediate family members which might be a source of stress to client.	Covered in all major references.

2. Records the presence or absence of at least 3 diseases with genetic tendencies among members of the extended family.

2. There are many diseases listed in the standard texts as having genetic or familial tendencies. The critical element requires that the presence or absence of three be noted.

EXAMPLE:

1. "No history of heart disease, cancer, diabetes or hypertension in immediate or extended family."

2. "Maternal grandmother and maternal aunt had diabetes and both died of strokes. No family history of cancer."

VI. Review of Systems (ROS)

Definition: The review of systems is a comprehensive account of the past and present status of each body system, obtained by direct questioning during the history-taking phase. This systematic fact-finding review prevents the omission of significant subjective data that relates to the present health status and that otherwise may have been overlooked.

Critical Elements:

1. Records, as a minimum, the presence or absence of the specific symptoms and/or conditions (past and present) listed on the form for each body system.

A. This section of the history-taking process tests ability to elicit information regarding the functioning of each of the body systems. On the physical form note that for each system, general areas are identified that give clues to common manifestations of pathology in that system. However, be sure to ask pertinent questions beyond those stated to make sure client does not have other symptoms. The section on Gynecology must be completed for male clients insofar as the suggested areas are applicable, i.e., contraception and dyspareunia.

Candidate will need to use knowledge of pathophysiology and skills in interviewing in order to ask questions in these general areas that will elicit the specific information needed.

EXAMPLES:

Eyes:
"Date of last eye examination."

References:

1) Reference 9-
Taking a Patient's History
This covers ROS and lists all of the symptoms that should be explored under each body system. These are quite classical and are covered in most medical assessment texts. (Such as references 7 or 24).

2) Reference 35
The book was written for beginning medical students to aid them in taking histories. At a very elementary level, it covers the common symptoms of disease relating to each system and gives some interpretation. It is an excellent beginning text for reviewing common problems that are presented by clients that could/should be explored in the ROS.

59

"Disturbances in vision"
If the client is asked if he or she has any "disturbances of vision," he or she may not understand what is being asked and may state "no" or he may forget that he has had a problem in the past unless reminded of the specific problem or symptom. The candidate will avoid those pitfalls by asking the client if he or she has had any of the common symptoms or complaints related to the eye, such as:

1. difficulty reading
2. difficulty with distance vision
3. blurring of vision
4. double vision
5. pain in the eye
6. spots before the eyes

Example:

Client is forty years old and might be at high risk for glaucoma. Ask if he has ever noted "A halo around lights."

A. Acceptable Recording:

Date of last Eye Examination

August 1, 1977

Disturbances in vision $\overline{0}$

B. More Complete Recording:

Near and far vision considered excellent by client. Denies blurring of vision, diplopia, pain and spots before eyes. No history of glaucoma in family.

3) References 5 or 6 and 27 may give helpful interviewing techniques.

60

60A

The acceptable recording given as an example would meet the critical element as long as the client in fact had no disturbances in vision. This will be validated by comparing findings with the client's initial interview. The tape recording of the history will also be available in case the client has a problem different than the one previously stated in his baseline data.

2. Records at least 2 factors related to onset, characteristics, or course since onset for 2 of the positive findings identified in the Review of Systems.

When a positive finding is identified in the Review of Systems, the candidate should ask the client about at least 2 related factors referring to onset, characteristics and course since onset. The candidate should attempt to identify the relationship of this symptom to other related or associated symptoms. For example: If client admits shortness of breath, then the candidate would want to explore the presence or absence of orthopnea and paroxysmal nocturnal dyspnea.

1. Medical and Surgical Texts list symptoms associated with major health problems.

2. Reference 35 is a simple but very helpful resource for this area.

3. Capell, Robert and Case, David B. Ambulatory Care Manual for Nurse Practitioners. Philadelphia: J.B. Lippincott, 1976. Written for Nurse Practitioners but really appropriate for baccalaureate level. Chapter II "Review of Major Disease Mechanisms and Interpretation of Symptoms," is particularly helpful. The other chapters are helpful but go into management which is beyond the scope of this examination.

Medical Texts

These are both more advanced, but valuable references:

MacBryde, Cyril M. and Robert S. Blacklow, Signs and Symptoms 5th ed. Philadelphia: J.B. Lippincott, 1970 Besides depth in applied pathophysiology and clinical interpretation.

EXAMPLES OF COMPLETE RECORDING:

"States he had frequent sore throats as a child. Two were severe enough to be hospitalized and treated with penicillin. Client thinks he might have had a 'strep throat' but doesn't remember any associated symptoms such as joint pain or heart problems."

The above recording is more than adequate in meeting the critical element and demonstrates that the nurse has used her knowledge of the relationship of strep infections and rheumatic fever. This knowledge made it possible for her to ask about commonly associated symptoms.

ACCEPTABLE RECORDING:

"States he had frequent, severe sore throats as a child. He was hospitalized twice for this problem."

UNACCEPTABLE RECORDING:

"Frequent sore throats."

63

93 A

tions of symptoms, has a good section on the review of symptoms.

Wasson, John et.al. The Common Symptom Guide. New York: McGraw-Hill Book Co., 1975.
A guide to the evaluation of 100 common adult and pediatric symptoms. Organization is a little confusing but for the beginner it can be used as a guide for appropriate history- associated symptoms and related physical examination.

PHASE II - PHYSICAL EXAMINATION

Critical Elements	Explanation	Resources/Learning Activities
I. GENERAL SURVEY		
1. Writes at least one general statement using objective characteristics to describe the physical status of the client.	1. The general statement should reflect candidate's initial impression of the client's overall physical health. Example: "White female of normal weight. Appears to be of stated age. In no acute distress."	1 & 2. Reference 4 is most specific. General Survey's covered in all the primary texts. Mental status may not be covered under General Survey. It may be covered separately or as part of the Neuro Assessment.
2. Writes at least one general statement using objective characteristics to describe emotional status of the client.	2. The general statement regarding the client's mental status will be developed from clues collected during the history-taking process. Example: "Oriented to time, place, person, cooperative during interview."	All major references. In addition, 24, 25, 26, 32 and 33 may assist you in the actual techniques of physical assessment.
3. Writes one general statement using objective terms describing the general condition of the skin.	3. The general statement describing the condition of the skin should be written following the physical examination. The statement might include generally acceptable descriptors of characteristics such as color, turgor, presence of scars, lesions etc.	3. Review (in any standard fundamentals, medical, surgical or health assessment text) the skills needed for gathering the objective data required in this section.
4. Records vital signs as indicated on form.	4a. Vital signs will be taken simultaneously by candidate and Evaluator. The findings obtained by the candidate must be equivalent to those of the Evaluator, according to the critical elements. A double stethoscope will be used for the blood pressure so it is heard simultaneously. The candidate must place the instrument at the proper location.	4. Use basic nursing text.

	4b. The candidate should signal when the count for pulse and respiration is to begin, and should start the count with zero. It is essential that both parties start and stop at the same time and begin with the same baseline (1 or 0).	
	c. To assure an accurate reading, the candidate is urged to count (or measure) the pulse, respirations and blood pressure <u>twice</u> BEFORE writing the result on the recording form. Except for unusual circumstances, the second readings are final and will be judged against the critical elements. In designating the systolic and diastolic sounds for blood pressure, the <u>first</u> sound and the <u>last</u> sound should be used; where a distinct change is heard but the beat continues, three figures may be used.	
	d. Be sure to use commonly accepted technique when weighing and taking client's height. Be sure to provide a clean barrier between client's feet and the scale.	
	e. The acceptable ranges for recording in this section are: 1. ± 6 millimeters for blood pressure 2. ± 2 respirations/minute for respiration 3. ± 5 beats/minute for pulse 4. ± 2 lbs. or 1 kg. for weight 5. ± ½" or 1 cm. for height	
II. <u>HEAD AND NECK</u>		
1. Inspects for obvious abnormalities of the face.	1. Note such characteristics as lesions color, texture, expression etc.	Covered in adequate detail in all of the primary texts. Review anatomy of the lymphatic chains.
2. Palpates skull surfaces for normal and/or abnormal findings in bony or soft tissue.	2. Any painful or swollen areas?	Reference 1 provides good visual diagram. Also Bates, Barbara (film) "The Head and Neck." (See audio-visual section of bibliography).

3. Palpates for pulsations over carotid arteries comparing quality, bilaterally.	3. Take careful note of the correct technique to palpate the carotid safely avoiding accidental massage of the carotid sinsuses.	Reference 14 may also be helpful.
4. Palpates anterior and posterior lymphatic chains in neck using palmar surface of fingertips and rotary motion.	4. When palpating for lymph glands proper technique is a focus of the critical element.	
5. Palpates neck for position of trachea.	5. Be sure to inform client what you are doing.	
6. Palpates for enlargement of thyroid gland using one of 2 approved techniques.	6. All of the texts cover palpation of the thyroid gland using either the anterior or posterior techniques.	
7. Records data required by the above critical elements including positive and negative findings.	7. Self explanatory.	
III. EYES		
1. Uses Snellen Chart to determine visual acuity (using glasses if glasses are worn).	1. A Snellen Chart will be available in the examining area. Record results of line which majority of letters are read correctly.	All primary texts cover this entire area. In addition, references 11 and 12 may be useful.
2. Tests near vision by using Snellen Near Vision chart or newsprint.	2. A Snellen Near Vision chart or a newspaper will be available in the examining room.	1-2. Practice using the Snellen charts. In many areas the school nurse would be a good resource for validation in this area. Eye and Pediatric Clinics might also provide areas for practice.

3. Inspects eyes and external structures surrounding eyes for abnormalities.	3. Include eyelids, eyebrows and eyeballs when checking for abnormalities (color, vascularity, edema etc.)	3. This is covered in great detail in reference 11. Presents excellent pictures of all common lesions. It provides an excellent review of the anatomical structures of the eyes.
4. Tests extraocular movement by having client follow finger through the 6 cardinal fields of vision.	4-8. Techniques used are those described in the Primary Texts. If abnormalities are noted in extraocular movements, the directional deviation should be noted. The candidate is not required to name the specific muscle or cranial nerve affected.	
5. Inspects for convergence.		
6. Tests peripheral vision by using confrontation technique.		
7. Inspects alignment of eyes for strabismus.		
8. Inspects for pupillary reaction to light.		
9. Inspects for the red reflex using opthalmoscope.	9. Use and familiarity with the function of the opthalmoscope is a prerequisite to elicit the red reflex. No funduscopic examination is required.	9. This skill can be learned by examining normal individuals.
10. Records data required by the above critical elements including positive and negative findings.	10. Self explanatory.	
IV. <u>EARS, NOSE & SINUSES, MOUTH & PHARYNX</u>		
1. Determines gross hearing by using whisper or watch test.	1. Be sure to perform one of these tests at the correct distance from the client's ears.	Covered in all Primary Texts. References 1 and 4 are particularly strong in this area. Reference 14 may provide indepth examination of the ears.
2. Inspects external structures of the ears for abnormalities.	2. Self explanatory.	

3. Inspects each ear canal for abnormalities using otoscope, without causing unnecessary discomfort to client.	3-4. Use and familiarity with the function of the otoscope is a prerequisite. Candidate should practice using the instrument and be able to place it in the ear without causing the client pain. Should be able to recognize the normal light reflex and be able to describe (not diagnose) deviations from the norm.	
4. Inspects each tympanic membrane for presence of landmarks.		
5. Inspects for patency of nose.	5. Candidate will have large tip or a nasal tip for the otoscope for examing the nasal membranes.	NOSE Covered in all primary texts. Descriptions and visuals most explicit in reference 2.
6. Inspects membranes of nares for discharge.	6-7. Self explanatory.	MOUTH and PHYARYNX
7. Palpates or percusses for tenderness over frontal and maxillary sinuses.		Covered in all primary texts. Practice examining the mouth and pharynx to develop expertise in identifying normal structures.
8. Inspects for presence or absence of lesions and signs of inflammation for 3 of the following areas: a. Gums b. Superior and inferior surfaces of the tongue c. Buccal mucosa d. Pharynx e. Tonsils	8. Inspection of the mouth of a client with dentures requires removal of the dentures.	
9. Inspects for presence/absence and condition of teeth using a direct source of light.	9. A flashlight and tongue blade will be available.	

10. Records data required by the above critical elements including positive and negative findings.	10. Self explanatory.	
V. CHEST AND LUNGS		
1. Inspects for abnormalities of the bony structures of both the anterior and posterior chest noting presence or absence of kyphosis, scoliosis and any other gross deviations. 2. Inspects for presence or absence of alterations in anterior posterior diameter noting barrel chest, if present. 3. Palpates for symmetry of respiratory excursion by placing hands on back at the inferior border of the rib cage with thumbs proximal to spinal column. 4. Palpates posterior chest wall for tactile fremitus comparing lung fields. 5. Percusses posterior chest wall bilaterally using mediate percussion technique. 6. Auscultates breath sounds over each lobe of the lungs moving the stethoscope systematically from side-to-side and top-to-bottom, over anterior, lateral, and posterior surfaces.	1-8. All techniques of assessment will be tested in this area. It is suggested that the inspection, palpation, percussion, auscultation sequence be used to obtain the essential data. Correct technique will be evaluated in this area. Any techniques described in a primary text will be accepted unless a specific technique is required by the critical element. Remember terms of common deviations must appear in the recording even when they are absent e.g.,"no barrel chest." 4-6. It is required that candidate work in a systematic fashion, side-to-side and top-to-bottom etc. as specified by the critical element.	Theory and techniques covered in all primary texts. Illustration excellent in reference 1 and 2. See also reference 18. For additional references, see section related to simulation - breath sounds. Breath sounds need to be learned by listening to sounds that are normal for the location. Adventitious sounds (abnormal) may be learned through listening to reference tapes or examining clients with known respiratory problems with an experienced examiner to validate your findings. (Testing of interpretation of breath sounds will be simulated in the laboratory.)

7. Describes adventitious respiratory sounds if present.		
8. Records data required by the above critical elements including positive and negative findings.		
VI. BREAST		
1. Inspects breast for shape and symmetry with the client in an upright position.	1-2. Area must be appropriately exposed.	Covered in all primary texts. References 1 and 2 are particularly strong with explicit visuals. The American Cancer Society Pamphlet on Breast Self-Examination provides good visuals of techniques used for each stage of the examination.
2. Inspects nipples for discharge and retraction with the client in an upright position.		
3. Inspects breasts for dimpling and retraction while client performs at least 1 of 3 accepted maneuvers.	3. The maneuvers refered to in this critical element are observations made with: (1) Arms overhead (2) Contraction of pectoral muscles (3) Leaning forward	
4. Palpates both breasts and axilla systematically for masses and tenderness, using palmar surface of fingers and using a technique of examination that can be documented in one of the major references.	4. It is important that correct technique be used in palpation of the breasts. It will be impossible to carry out an adequate examination of the axilla with long finger nails without causing discomfort.	
5. Records data required by the above critical elements including positive and negative findings.	5. Self explanatory.	

VII. HEART		
1. Inspects anterior chest wall for presence or absence of pulsations or heaves.	1. While a reference may indicate a client may be sitting up or supine, a more accurate finding is elicited with the patient supine.	Material is covered in all primary assessment texts. In addition, references 19 and 20 may be helpful. Also see section on simulation - Heart sounds. Be familiar with anatomical landmarks and lines of references on the chest. Practice listening to heart sounds on normal individuals at the various valvular areas to identify normal S_1 - S_2 for each area is advised. Listening to simulated heart sounds is helpful. See references for tapes and records available for purchase or possible library loan.
2. Palpates anterior chest wall for point of maximum intensity (P.M.I.) and if identifiable, notes anatomical location.	2. Exact location (by measurement) of P.M.I. does not have to be identified, rather its general location if present. Record "P.M.I. not palpable," if that is truly the case.	
3. Listens to cardiac sounds over the 4 valvular areas using <u>both</u> the bell and diaphragm of the stethoscope for each area.	3. Usually performed by listening to all valvular areas with diaphragm, then all valvular areas with bell. Be exact in your locations of the valvular areas.	
4. Listens to heart beat noting rhythm.	4. The rhythm must be described in the write-up.	Listening to abnormal heart sounds with a preceptor for validation is highly recommended for synthesis following experiences suggested above.
5. Describes grossly abnormal cardiac sounds, if present.	5. For purposes of this examination a candidate would not be expected to recognize a murmur below grade III/VI.	
6. Records data required by <u>EACH</u> of the above critical elements including positive and negative findings.	6. Self explanatory.	
VIII. ABDOMEN		
1. Inspects abdomen for contour and lesions (including surgical scars).	1. Be sure to expose the entire abdomen to detect scars or lesions.	All primary references cover this area. In addition, reference 10 may be helpful. Practice technique to develop skill in percussion of abdomen.
2. Listens for the presence of bowel sounds using a stethoscope.	2. Auscultate prior to percussion and palpation.	Be familiar with quadrants of abdomen and the location of organs in each quadrant.

3. Percusses all 4 quadrants of abdomen describing deviations in percussion sounds, using mediate percussion technique.	3. Correct technique needed to elicit percussion notes. Any techniques described in a primary text will be accepted.	
4. Performs deep palpation to identify the inferior borders of the liver while client takes deep breaths.	4. The edges of the liver may be hard to locate or may not be palpable. Therefore, be sure the abdomen is relaxed. Take time to confirm findings.	
5. Performs light palpation over the 4 quadrants to determine the presence and location of: a) tenderness b) masses	5. Acceptable palpation techniques are found in any of the major texts.	
6. Records data required by the above critical elements including positive and negative findings.	6. Self explanatory.	
IX. CRANIAL NERVES		
1. Examines systematically all 12 cranial nerves. Tests 1 sensory or motor function for a minimum of 9 cranial nerves to determine presence or absence of normal function.	1. Function (sensory, motor or both) of all cranial nerves should be tested in order I-XII. To pass critical element candidate needs to correctly assess only 1 function (sensory or motor) for a minimum of 9 cranial nerves.	Primary references 2 and 4; secondary references 15, 16, 17 are especially thorough. Systematic practice using a guide will be helpful in learning this part of the examination
2. Records data required by each critical element including positive and negative findings.	2. Self explanatory.	

X. REFLEXES		
1. Stimulates the required deep tendons bilaterally to elicit a response using a reflex hammer.	1-2. Client must relax extremity. Tendon must be partially stretched to elicit reflex.	Techniques are covered in all primary references. Practice to become comfortable with reflex hammer and able to relax the client.
2. Stimulates the plantar reflexes bilaterally.		
3. Records on the stick figure an estimate of each tendon response elicited for the respective site using a scale of 0-4, and reccrds plantar response.	3. Self explanatory.	
XI. SENSORY AND MOTOR STATUS		
1. Observes bilateral responses to light touch and painful stimuli on the distal portion of extremities.	1-6. Self explanatory	Reference 1 describes these procedures in detail.
2. Observes for strength in lower extremities by having client perform shallow knee bend.		
3. Observes for strength of upper extremities by testing hand grip bilaterally.		
4. Observes muscle tone in extremities while passively moving extremities through range of motion.		
5. Observes for abnormalities in gait by having client walk.		

6. Records data required by the above critical elements including positive and negative findings.		
XV. BACK AND EXTREMITIES		
1. Directs client to move neck through its range of motion.	1. Employ technique of complete active range of motion (R.O.M.) through all planes.	Covered in all primary references; however, reference 1 is especially good.
2. Inspects back for structural changes of spine (including contour, and presence of kyphosis or scoliosis).	2-3. Observe with patient standing. Functional scoliosis disappears when bending forward. The terms kyphosis and scoliosis must appear in the recording.	
3. Inspects the spine while client is bending forward, describing observed function and structure.		
4. Palpates spinal column to detdetermine presence or absence of tenderness.	4. Self explanatory.	
5. Inspects all joints or extremities noting enlargement and/or deformity; including shoulders, hips, elbows, wrists, fingers, knees and ankles.	5-8. Include upper extremities: shoulders, elbows, wrists, hands. Lower extermities: hips, knees, ankles, feet. Technique of active range of motion is employed. It is not necessary to measure R.O.M. of joints. Work systematically - proxiaml-to-distal, top-to-bottom. Be sure to instruct client to move joints through all planes of R.O.M.	
6. Palpates all joints of extremities noting tenderness: including shoulders, hips, elbows, wrists, fingers, knees and ankles.		
7. Inspects muscle of extremities noting symmetry.		
8. Directs client to move 4 of the major joints through range of motion, bilaterally, noting function. This must include shoulders and hips and any 2 of the other major joints (elbows, wrists, hands, knees, ankles).		

9. Records a summary of positive and negative findings elicited by the critical elements above describing specific deviations from normal structures and functions.	9. Record full R.O.M. for abnormal findings: a) Specify joints assessed for abnormal findings. b) Specify if range of motion is "minimally" or "markedly" decreased.	Adequately covered in references 1, 2, or 4.
XIII. CIRCULATORY STATUS OF EXTREMITIES		
1. Inspects distal portions of extremities for circulatory status describing at least 2 characteristics: color, temperature, pigmentation, texture, etc.	1-3. Self explanatory.	Covered in references 1 or 2. In addition, reference 21 might be helpful.
2. Palpates for edema by pressing against ankle or shin and observing for pitting.		
3. Palpates radial, femoral and dorsalis pedis pulses bilaterally to determine their presence and relative strength, or absence.		
4. Records data required by EACH of the above critical elements including positive and negative findings.	4. Record pulses using either narrative or record on stick figure. Femoral pulses frequently included in examinatoin of abdomen - for this examination include here.	

PHASE III - SUMMARY & ANALYSIS

GUIDELINE	EXPLANATION	LEARNING ACTIVITIES
A. Data Recording:		
1. Records subjective and objective data gathered during the history and physical examination in designated categories on the form provided.	The candidate records data collected during history and physical examination on form provided. Candidate may find it helpful to rewrite the section on analysis of a symptom, otherwise recording made during the history and physical may be submitted. The recording time is provided so that the candidate has the opportunity to not only record but to analyze the data collected so that problems may be identified. Check recording for completeness. The client will remain in the exam area ONLY for the first 15 minutes of the Summary phase in case the candidate wants to recheck or perform a test previously omitted. Thereafter, clients leave the test site and are not available to candidates.	Covered in most primary texts. Reference 4 and 7 especially good. Practice soaping common health problems derived from health histories and physicals done utilizing the critical elements.
B. Problem Statements		
1. Identifies two actual or potential problems based on the data collected during the history and physical examination.	Based on an analysis of the data and the candidate's understanding of the meaning of the data, the candidate identifies and records on the space provided two (2) problems or health concerns. A problem is defined as any aspect of the client's life which requires nursing intervention or further evaluation or which interferes with the quality of life as perceived by the client or the candidate. The focus is on nursing problems rather than identification of medical diagnoses. Problems may be actual, this is currently existing such as overweight, anxiety, etc.,	

	or potential, such as high risk to cardiovacsular disease or potential parenting problems. The problem stated must reflect the data collected. There must be sufficient data recorded in the history and physical to warrant the problem being identified. For example, the candidate should not conclude that a client is anxious if the client does not state, or if there are no behavioral observations that suggest anxiety.
2. Writes a problem-oriented analysis (SOAP format) for one of the problems identified above including comments in the following categories:	
NOTE: While the SOAP note is utilized in clinical practice to write brief progress notes, for the purpose of this examination, the SOAP note is seen as the place to demonstrate your analytical skills. It should therefore be as complete as possible. Aim for completeness, rather than brevity.	
a. Subjective data relevant to the health concern.	Candidate should record all the subjective data, that is, all the information the client has told the candidate that is relevant to the particular problem the candidate is analyzing. Relevant data would include information concerning the onset, characteristics, and course since onset of the particular problem or concern, the client's perception, or understanding of the problem, factors from the client's activities of daily living affected by the concern or problem, personal or social factors affected by the problem or concern, environmental factors related to the concern. Any previous illness of the client or in the client's family that may have some effect on the client's present concern should be recorded. The candidate should identify not only significant positives (those factors that are present) but also significant negatives (those factors that by their absence further define

90

90A

the problem) in the subjective data.

It would not be sufficient therefore to only record under subjective data "client states his back aches." Further description is necessary.
For example: "Client states his back aches. Characteristically pain begins in sacral area and radiates down right leg especially after lifting heavy objects or turning certain way. Some relief with bedrest."

b. Objective data relevant to the health concern.

Here the candidate should include all observations during the history and physical of the client that are relevant to the problem or concern. This would include observations concerning the general health status, psychological or behavioral observations as well as any physical data collected during the physical examination which defines the client problem. Both significant positives and negatives that are related to the client's problem or help to define it should be included. Example: If the health problem is constipation and there are no positive findings on the abdominal exam, the pertinent negatives should be included as follows:

Abdomen: Soft, non-tender, no masses palpated, flat. Normal tympany throughout. Normal bowel sounds present.

The candidate may record the data in either narrative or categorical form.

c. Assessment of the data related to the health problem including such factors as the nature of the problem and its impact on daily living.

This is the candidate's opportunity to state his/her understanding of the meaning of the data. Assessment must be derived logically from the subjective and objective data. Such factors as: what the problem is, what the cause of the problem is suspected to be, and what impact the problem is currently having on the client's ability to function in his daily living may be included in the assessment statement. Either narrative or nursing diagnostic format may be used. Statement may also reflect client's progress made in dealing with the problem. The assessment write up should further define or clarify the original problem.

Example: Acceptable - the client is overweight as a result of inadequate information concerning nutrition. This has affected her ability to prepare nutritious foods for herself and family.

Unacceptable: "Overweight"

d. A nursing plan that reflects consideration of such factors as: data obtained, additional data to be obtained, nursing treatment client teaching, referral/consultation.

The plan designed by the candidate must be logically related to the assessment statement. It should reflect the data that has been gathered and analyzed. Nursing activities related to specific nursing therapies, teaching referral, and consultation may be included as well as plans to further define the problem through ongoing data collection.

Reference 4 devotes the first chapter to a discussion of the problem - oriented approach and gives examples of SOAP notes throughout the book at the end of most chapters.

Vaughan-Wroebel, Beth. C. and Betty Henderson. The Problem-Oriented System in Nursing: A Workbook St. Louis: C.V. Mosby, 1976. Provides a comprehensive presentation of the problem-oriented system, and its use in nursing practice. Candidates may wish to utilize the many exercises provided to practice writing SOAP notes. Reference 7, 8 or 28 also helpful.

92

List of Acceptable Abbreviations

Below is a list of abbreviations which are acceptable for use on the Health Assessment Record Form during the examination. No other abbreviations may be used.

Abd.	-	Abdominal
A-P	-	Anterior - Posterior
BM	-	Bowel movement
B.P.	-	Blood pressure
BUN	-	Blood urea nitrogen
CA	-	Carcinoma
Cal.	-	Calorie
CBC	-	Complete blood count
C.C.	-	Chief complaint
cc	-	Cubic centimeter
C.H.F.	-	Congestive heart failure
CNS	-	Central nervous system
C.V.A.	-	Cerebrovascular accident, a stroke
$\overline{c}$	-	With
DPT	-	Diphtheria, pertussis, tetanus
D & C	-	Dilatation & Curettage
D.T.R.	-	Deep tendon reflexes
Dx	-	Diagnosis
E.E.N.T.	-	Eye, Ear, Nose, Throat
E.E.G.	-	Electroencephalogram
E.K.G./E.L.G.	-	Electrocardiogram
E.N.T.	-	Ear, nose, throat
E.O.M.	-	Extraocular movements
FBS	-	Fasting blood sugar
GC	-	Gonorrhea, gonococcal
G.I.	-	Gastrointestinal
GM	-	Gram
GR.	-	Grain
G.U.	-	Genitourinary
GYN	-	Gynecology
Hct.	-	Hematocrit
Hgb.	-	Hemoglobin
H_2O	-	Water
Hx	-	History
I & O	-	Intake & Output
IVP	-	Intravenous pyelogram
L	-	Liter
L.L.Q.	-	Left lower quadrant
L.S.B.	-	Left sternal border
L.U.Q.	-	Left upper quadrant
O.D.	-	Right eye
O.S.	-	Left eye
O_2	-	Oxygen
O.U.	-	Both eyes
PERRLA/PERLA	-	Pupils equal round & respond to light & accommodation
PMI	-	Point of maximum intensity
Post-op	-	After surgery
P.O.	-	By mouth
Pre-op	-	Before surgery
Prn	-	As needed
Pt.	-	Pint; Patient
R.B.C.	-	Red blood cells; red blood count
R.L.Q.	-	Right lower quadrant
R.U.Q.	-	Right upper quadrant
$\overline{s}$	-	Without
$\overline{ss}$	-	Half
Stat.	-	Immediately
t	-	Teaspoon
T	-	Tablespoon
T & A	-	Tonsillectomy & Adenoidectomy
TB	-	Tuberculosis
Temp.	-	Temperature
T.P.R.	-	Temperature, Pulse, Respiration
T.U.R.	-	Transurethral resection of the prostate
VD	-	Venereal disease
W.B.C.	-	White blood count
Wgt.	-	Weight

1/80

PROPERTY OF THE REGENTS
EXTERNAL DEGREE PROGRAM

DO NOT REPRODUCE

University of The State of New York

New York Regents External Degrees in Nursing

Bachelor of Science (Nursing)

HEALTH ASSESSMENT PERFORMANCE EXAMINATION

S A M P L E S A M P L E

Health History and Physical Examination Record

Date: July 1, 1979

Name of Candidate (print) Jane Doe S.S.# 000-00-0000

Candidate (sign) Jane Doe

Examination Location: Albany Medical Center

Name of Evaluator (Print) Mary Hansen

PHASE I: HEALTH HISTORY

I. DEMOGRAPHIC DATA

Name Elizabeth Cooper Age: 26 Sex: F

Address 60 Smith Street Ethnic Origin: English-Irish

Albany, New York Religion: Unitarian

Health Insurance: Yes X No Marital Status: Single

Current Occupation and Title: Paralegal

II. REASON FOR CONTACT:

School Physical - Client is entering law school

III. EXPLORATION OF CURRENT HEALTH STATUS

A. Perception of Health, with identification of any health concerns

Client states "she has always been healthy" but has had frequent indigestion

III. EXPLORATION OF CURRENT HEALTH STATUS (con't)

B. Analysis of a symptom, if present

(Onset, Characteristics, Course Since Onset)

Client has always been "indigestion prone." She can remember her mother giving her bicarbonate of soda as a child. She was troubled with indigestion when she first went to college but it went away before she needed to see a doctor. Within the last month she has again noted a gradual increase in incidence of indigestion. Upon questioning, cli[illegible] admitted that there might be a relationship between the onset of ind[illegible]s-tion and her decision to give up work and attend law school.

Indigestion is described as burning in the epigastric area. The symptom appears most frequently mid-morning and a couple of hours after dinner. In the morning she usually gets relief following coffee break. In the evening she takes bicarbonate of soda with prompt relief.

She denies any episodes of vomiting or black stools.

Symptom has not increased in severity or frequency in last week.

WORK PAPER

This paper is for taking notes during the health history. Particularly in the areas of "Reason for Contact." "Exploration of Current Health Status" and "Analysis of a Symptom." you may want to make notes and then fill in the actual form during Phase III Summary.

C. ACTIVITIES OF DAILY LIVING

1. Nutrition

a. 24 hour intake:

Time	Food/Fluid	Other Factors, i.e. Approximate Amount
7 a.m.	Juice	6 oz
	Tea	1 cup
	Egg	1
	Toast	1 slice with butter
10 a.m.	Coffee Jelly Doughnut	varies
12-1	Often eats hamburger, pizza or fast foods, or has it sent in to office	
6	Chicken - fried	1 piece
	Vegetables	1 cup
	Rice	1 cup
During day	Coffee	4-5 cups

b. Additional Data:

Does not like milk

2. Exercise - Sleep

Since working, she is unable to exercise in a regular patterned way. She does some walking but feels it is insufficient. Resting is reading a good book and sleep is generally from 11 p.m. - 6 a.m. or 12 to 7 a.m.

3. Elimination

Voiding occurs 3-4 times/day. Does not regularly void during 8 hours of work. Bowel movements are 1/day-brown, soft, well-formed. No concern with pattern.

4. Work - Recreation

Work consists of being a paralegal in an active law office where she is given a great deal of responsibility. For recreation she plays tennis with her boyfriend once a week and dates. She has little time for other recreation.

5. Tobacco

Smokes ½ pack - cigarettes/day. Smoked over a pack/day when in college.

6. Use of Alcohol/Mood-Affecting Drugs

Usually drinks wine with dinner and has an occasional cocktail on weekends. Denies use of drugs or marijuana.

7. Satisfaction or Concerns with Patterns

Client is happy about decision to return to school but expresses concern about separation from boyfriend. Satisfaction with work motivated decision to go to law school.

D. PERSONAL/SOCIAL HISTORY

1. Interactions with Significant Others

Ms. Cooper gets along well with parents with whom she lives. She often visits her brother and sister-in-law and their 4 children who live nearby. She particularly enjoys playing with the children She says that she & her boyfriend "understand each other." He supports her decision to go to law school and thinks it will be great to have a lawyer as a wife.

2. Feelings about Self

She enjoys her work but knows she gets unduly upset when she makes a mistake, but tries to keep it inside. She feels that people perceive her as self-confident, but does not perceive herself that way.

E. ENVIRONMENT

1. Physical Conditions of Home/Work/School

Lives in a spacious 1 family house with own room and bath. Intends to have her own apartment when in law school. Works in a modern office of a large law firm. Offices are spacious and temperature (heat and airconditioning) is well controlled.

2. Transportation

No problem - owns and drives own car

3. Community Characteristics

Lives in upper middle class suburban area with shopping, churches and schools nearby. Close to more populated urban areas.

4. Economic Resources

Has saved some money in 4 years of working. Parents and grandparents are planning to fund law school.

IV. HISTORY OF PAST HEALTH-ILLNESS

A. Illnesses, Immunizations, Use of Medications

1. Common Communicable Diseases

	Yes	No	Approx. Age		Yes	No	Approx. Age
Measles	___	✓	___	Diphtheria	___	✓	___
Mumps	___	✓	___	Scarlet Fever	✓	___	Childhood
Chicken Pox	✓	___	Childhood	Polio	___	✓	___
Rubella	✓	___	Childhood	Infectious Mono-nucleosis	___	✓	___
Rheumatic Fever	___	✓	___	Tuberculosis	___	✓	___

Sequellae: No sequellae. Does not remember exact ages.

2. Immunizations

	Yes	No		Yes	No
Measles	✓	___	Diphtheria/Tetanus	✓	___
Mumps	✓	___	Pertussis (DPT)	✓	___
Rubella	___	✓	Booster	✓	___
Smallpox	✓	___	Flu	✓	___
Polio (initial)	✓	___	Tetanus (booster)	Date: 1971	
Polio (booster)	✓	___	Tuberculin Test:	Date: 1971	
				Result: Negative	

3. Allergies: (i.e., Animals, Blood, Contact Agents, Food, Inhalants, Penicillin and/or other Drugs, etc.)

Yes ✓ No ___

Substance(s) Adhesive tape

Description of type of reaction(s) and related treatment:

Blisters under tape
Has never had reaction to penicillin

4. Past Major Illnesses

Illness	Approximate Age	Sequellae if any

a. Physical or Emotional Illness(es)

Client describes her physical and emotional status as being good and never has suffered a serious illness which required hospitalization.

b. Surgical Procedure(s)

Had tonsillectomy at 4 years of age

c. Accident(s) or Injury(ies)

Had "tennis elbow" approximately 1 year ago but has had no recurrence or difficulty since resuming tennis 6 months ago.

5. Medications

Drug	Frequency	Reason for Use
Bicarbonate of soda 1 tsp. in water	1-2 times daily	to relieve indigestion
Tums	on occasion	to relieve indigestion

V. HISTORY OF FAMILY HEALTH-ILLNESS

A. FAMILY HEALTH STATUS - (Immediate family members- parents, children, siblings, spouse/living partner)

Relation to Client	State of Health	Current Age	Disease(s) and Age at Onset	If Deceased, Cause & Age at Death
Mother	Living & well	55		
Father	Living	60	Peptic ulcer Gastrectomy at 40 years old	
Brother	Living	32	Peptic ulcer	

B. COMMON DISEASES WITH GENETIC TENDENCIES - (within extended family)

Maternal grandfather - alive - Heart attack at 70 following long history of hypertension

Paternal grandfather - deceased at age 40, cause unknown

No history of cancer or diabetes in immediate or extended family

VI. REVIEW OF SYSTEMS

(Respond by using the following key:)

Key: $\bar{o}$ = Absent

\+ = Present, requiring recorded exploration

A. General State of Health:
General well-being - Good general health

Recent changes in weight $\bar{o}$

Other $\bar{o}$

B. Integumentary System:
Eruptions/Lesions $\bar{o}$

Pruritus - Head - Used to itch from dandruff. Relief obtained from weekly use of the tar shampoo prescribed by dermatologist 3 years ago.

Other $\bar{o}$

C. Head:
Headaches $\bar{o}$

Trauma to head $\bar{o}$

Other $\bar{o}$

D. Eyes:
Date of last eye examination 1 year ago

Disturbances in vision $\bar{o}$

Other - Corrective lenses for astigmatism

E. Ears:
Recurrent infections + States she has had frequent episodes of external otitis usually related to scratching itchy ears. Relieved by ear drops prescribed by physician. Has not had episode in last 3 years

Disturbances in hearing $\bar{o}$

Other $\bar{o}$

F. Nose and Sinuses:
Pain ō
Discharges and/or post nasal drip ō
Obstruction ō
Epistaxis ō
Other ō

G. Mouth and Throat:
Date of last dental exam: 6 months ago
Recurrent sore throat or tonsillitis
Hoarseness or change in voice ō
Pain, soreness or lesions ō
Disturbances in chewing and/or swallowing ō
Other ō

H. Respiratory:
Coughing ō
Wheezing ō
Shortness of breath ō
Pain ō
Other ō

I. Cardiovascular:
Chest pain ō
Shortness of breath ō
Edema ō
Hypertension/Hypotension ō
Heart Murmur ō
Disturbances in cardiac rate or rhythm ō
Other ō

J. Gastrointestinal:
Appetite changes ō
Disturbances in digestion + See analysis of symptom for details
Jaundice ō
Changes in bowel habits ō
Constipation/Diarrhea ō
Blood in stool ō
Other ō

K. Genito-Urinary:
Hematuria ō
Kidney or bladder problems ō
Nocturia ō
Venereal disease ō
Impotency ō
Disturbances in urination ō
Other ō

L. Endocrine:
Polyuria ō
Polydipsia ō
Polyphagia ō
Thyroid problems ō
Other ō

M. Hematopoietic:
Bruising ō
Anemia ō
Enlarged glands ō
Other ō

N. Musculoskeletal:
Disturbances in muscles and/or joints +
Other 0

"Tennis Elbow" 1 year ago. Onset following 2 weeks at tennis camp. Following medical treatment there has been no reoccurrence. Problem no longer interferes with usual pattern of tennis on weekends.

O. Neurological:
Seizures 0
Memory loss 0
Paralysis 0
Sensory disturbances 0
Vertigo 0
Tremors 0
Syncope 0
Other 0

P. Gynecology:
Contraception +
Dysparunia 0

Client has been relying on boyfriend's assuming responsibility for contraception. He uses a condom on her fertile days. They have been sexually active for approximately 1 year.

Venereal disease 0
Breast problems 0
Vaginal discharges 0
Date of last pap smear 1 mo. ago

Menstrual history:

Age at onset 12 Duration 4-5 days
Frequency Approx. every 30 days
Age, at onset of menopause -

Obstetrical history:

No. of pregnacies 0 No. of deliveries N/A
No. of abortions 0 No. of living children N/A
Other 0

Phase II: PHYSICAL EXAMINATION

I. GENERAL SURVEY

General physical status: White, well-developed 26 year-old female appearing younger than her stated age.

General mental status: Appears to be intelligent and articulate, oriented to time, place and person

General condition of skin: Olive in color, normal turgor without lesions

Vital signs

BP 118/82 P 96 Resp 18 Weight 130 Height 5'6"

II. HEAD AND NECK (including face, skull, neck, etc.)

Normal cephalic. Normal distribution of hair $\bar{0}$ evidence of dandruff. Symmetrical. No bony tissue abnormalities. Normal facies. Carotid arteries 2 + bilateral. No lymphadenopathy. Trachea midline. Thyroid palpable no enlargement without nodules.

III. EYES (including vision, external structures, red reflex, etc.)

Lids normal without lesions or inversion. No ptosis. Conjunctivae clear sclerae white. No defects of cornea or iris evident. Pupils equal, react to light and accommodation (PERLA) Extraocular movements normal (EOM), normal fields by confrontation. No nystagmus or strabismus. Snellen 20/20 OD, 20/20 OS. Near vision, able to read newspaper print. Convergence normal. Red reflex present, clear.

IV. EARS, NOSE & SINUSES, MOUTH & PHARYNX (including hearing, external structures, tympanic membrane, nares, sinuses, membranes, teeth, gums, tongue, mucosa, pharynx, etc.)

Gross hearing adequate by whisper test bilaterally. No abnormal structure of the pinna. No tenderness over mastoid sinuses bilaterally. No lesions, drainage or masses noted in ear canal. Both tympanic membranes visualized, light reflex present. Nose - patent bilaterally without tenderness over sinuses, slight mucoid discharge. Teeth present in good, repair. Buccal mucosa, gums, pharynx without inflammation or lesions. Uvula rises in midline on phonation.

V. CHEST AND LUNGS (including external structures, anterior-posterior diameter, excursion, fremitus, resonance, breath sounds, etc.)

Thorax is symmetrical without barrel chest, kyphosis or scoliosis. A-P diameter not increased. Respiratory excursion symmetrical on posterior surfaces. Fremitus equal bilaterally. Lung fields resonant throughout. Breath sounds normal vesicular throughout peripheral lung fields. No rales, rhonchi, or rubs.

VI. BREASTS (including shape and symmetry, tissues, etc.)

Breasts are symmetrical, contour + consistency normal. No retraction of nipples, $\bar{s}$ discharge. Breast free of masses + tenderness. No axillary nodes palpable.

VII. HEART (including rate, rhythm, pulsations, heaves, P.M.I., thrills, heart sounds, murmurs/abnormal sounds, etc.)

No pulsations or heaves on anterior chest wall. Apical Impulse (PMI) at 5th left intercostal space at mid clavicular line. No thrills or pulsations over valvular areas. S_1 heard loudest at apex. S_2 loudest at base of pulmonic area. No murmurs heard. Rhythm regular. Apical pulse - 96

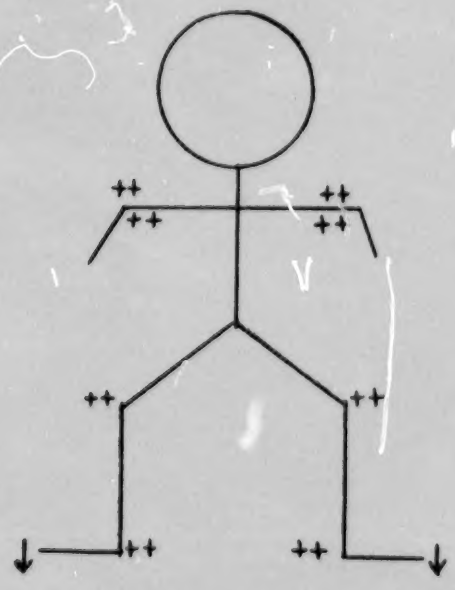
VIII. ABDOMEN (including external surface, sounds, organs, abnormalities, etc.)

Abdomen flat and soft, no scars or striae. Bowel sounds present. Normal abdominal tympany liver edge percussed and palpated at costal margin. Spleen not palpable. No tenderness or masses noted on palpation.

IX. CRANIAL NERVES

1. olfactory - able to identify ammonia
2. optic - Snellen 20/20 OD, 20/20 OS
3. oculomotor - 3,4,6 EOM intact, PERLA, no ptosis, no nystagmus
4. trochlear - See above
5. trigeminal - sensory intact, jaw closure normal
6. abducens - see above
7. facial - facial muscles symmetrical, no weakness
8. acoustic - hearing intact, normal whisper test, weber test normal
9. glossopharyngeal } swallowing & gag reflex present uvula rises midline
10. vagus } on phonation
11. spinal accessory - head movement and shrug of shoulders normal
12. hypoglossal - tongue protrudes in midline, no tremor

X. REFLEXES (biceps, triceps, patella, achilles, plantar)



XI. SENSORY AND MOTOR STATUS (including sensation, motor function, coordination, etc.)

Motor	Sensory
Client able to perform shallow knee bend without difficulty. Firm hand grip Present and equal bilaterally No involuntary movements, tremors or tics. Resistance to passive stretch normal.	Sensory intact to light touch and pinprick bilaterally on all extremities

Cerebellar function: gait normal, Romberg negative

Cerebral function: alert, responsive thought processes, memory + orientation intact. Behavior and speech appropriate.

XII. BACK AND EXTREMITIES (including shoulders, hips, and any other 2 joints, muscular symmetry, abnormalities, etc.)

Range of motion normal in neck, shoulders, elbow, wrist, hip & knees.
Normal spinal curvature & mobility. No kyphosis or scoliosis.
No spinal tenderness.
Muscles symmetrical bilaterally
No joint tenderness or deformity

XIII. CIRCULATORY STATUS OF EXTREMITIES (including skin characteristics, pulses, abnormalities, etc.)

Extremities warm to touch, hair distribution normal, nails pink and healthy without cyanosis. Varicosities not noted on legs. No evidence of ankle edema.

Femoral, dorsalis pedis + radial pulses present, strong and equal bilaterally.

Phase III - SUMMARY

A. Records all data on the form provided.

Summary of Health Care Problems

B. Problem Statements

1. Lists 2 actual or potential health problems identified:

1. Indigestion - possibly related to stress. Strong family history of peptic ulcer indicates need for health teaching.

2. Inadequate birth control measures indicate need for evaluation of attitudes and knowledge of birth control and need for health teaching.

2. Problem-Oriented Analysis (SOAP Format) for 1 health problem identified:

1. Indigestion

Subjective - Client complains of intermittent burning epigastric discomfort 2-3 hours following breakfast and dinner. History of intermittent indigestion of this type over the years. Onset of this episode 1 month ago. Relief obtained by intake of food or bicarbonate of soda. Symptoms have not increased in severity or frequency since onset. Client's last episode of this symptom was during first semester at college. She believes her recent decision to attend law school may be related to onset. Admits to being tense and keeping things bottled up inside herself, lacking self-confidence concern over leaving her boyfriend. Strong family history of peptic ulcer disease. Denies vomiting and black stool and change in appetite.

Objective - Abdomen flat and soft, no scars or striae. Bowel sounds present. Normal abdominal tympany liver edge percussed and palpated at costal margin. Spleen not palpable. No tenderness or masses noted on palpation.

Assessment - Client may be developing a stress-related peptic ulcer. This is of particular concern now since client is leaving job and returning to school.

Plan - 1. Teach client about the physiology of digestion and about stress and their relationship to development of peptic ulcer.

2. Teach client the role of diet and use of antacids in preventing symptoms of indigestion.

3. Advise client to consult physician if relief is not obtained by use of preventive measures and if any increase in severity is noted. Emphasize role family history may have in making her more prone to peptic ulcer disease.

PRACTICE SHEETS

The following pages (85-102) include a copy of the form that candidates will use during the Health Assessment portion of the examination. Candidates are encouraged to use the enclosed sample for purposes of practice, but are reminded that all materials in the study guide are copy-righted by The University of the State of New York Regents External Degree Program and are for the exclusive use by the program and its candidates.

PROPERTY OF THE REGENTS
EXTERNAL DEGREE PROGRAM

University of The State of New York

New York Regents External Degrees in Nursing*

Bachelor of Science (Nursing)

HEALTH ASSESSMENT PERFORMANCE EXAMINATION

Date: _____

Name of Candidate (print) _____ S.S.# _____

Candidate (sign) _____

Examination Location: _____

Name of Evaluator (Print) _____

PHASE I: HEALTH HISTORY

I. DEMOGRAPHIC DATA

Name _____ Age: _____ Sex: _____

Address _____ Ethnic Origin: _____

_____ Religion: _____

Health Insurance: Yes___ No___ Marital Status: _____

Current Occupation and Title: _____

II. REASON FOR CONTACT:

III. EXPLORATION OF CURRENT HEALTH STATUS

A. Perception of Health, with identification of any health concerns

* These materials are protected by copyright law and may be reproduced by candidates for practice use ONLY.

WORK PAPER

This paper is for taking notes during the health history. Particularly in the areas of "Reason for Contact." "Exploration of Current Health Status" and "Analysis of a Symptom." you may want to make notes and then fill in the actual form during Phase III Summary.

VII. EXPLORATION OF CURRENT HEALTH STATUS (con't)

B. Analysis of a symptom, if present
(Onset, Characteristics, Course Since Onset)

C. ACTIVITIES OF DAILY LIVING

1. Nutrition

a. 24 hour intake:

Time	Food/Fluid	Other Factors, e.g., Approximate Amount

b. Additional Data:

2. Exercise - Sleep

3. Elimination

4. Work - Recreation

5. Tobacco

6. Use of Alcohol/Mood-Affecting Drugs

7. Satisfaction or Concerns with Patterns

D. PERSONAL/SOCIAL HISTORY

1. Interactions with Significant Others

2. Feelings about Self

E. ENVIRONMENT

1. Physical Conditions of Home/Work/School

2. Transportation

3. Community Characteristics

4. Economic Resources

IV. HISTORY OF PAST HEALTH-ILLNESS

A. Illnesses, Immunizations, Use of Medications

1. Common Communicable Diseases

	Yes	No	Approx. Age		Yes	No	Approx. Age
Measles	___	___	_____	Diphtheria	___	___	_____
Mumps	___	___	_____	Scarlet Fever	___	___	_____
Chicken Pox	___	___	_____	Polio	___	___	_____
Rubella	___	___	_____	Infectious Mono-nucleosis	___	___	_____
Rheumatic Fever	___	___	_____	Tuberculosis	___	___	_____

Sequellae:

2. Immunizations

	Yes	No		Yes	No
Measles	___	___	Diphtheria/Tetanus	___	___
Mumps	___	___	Pertussis (DPT)	___	___
Rubella	___	___	Booster	___	___
Smallpox	___	___	Flu	___	___
Polio (initial)	___	___	Tetanus (booster) Date:	_____	
Polio (booster)	___	___	Tuberculin Test: Date:	_____	
			Result:	_____	

3. Allergies: (i.e., Animals, Blood, Contact Agents, Food, Inhalants, Penicillin and/or other Drugs, etc.)

Yes ____ No ____

Substance(s)_____

Description of type of reaction(s) and related treatment:

4. Past Major Illnesses

Illness	Approximate Age	Sequellae if any
a. Physical and/or Emotional Illness(es)		
b. Surgical Procedure(s)		
c. Accident(s) or Injury(ies)		

5. Medications

Drug	Frequency	Reason for Use

V. HISTORY OF FAMILY HEALTH-ILLNESS

A. FAMILY HEALTH STATUS - (Immediate family members - parents, children, siblings, spouse/living partner)

Relation to Client	State of Health	Current Age	Disease(s) and Age at Onset	If Deceased, Cause & Age at Death

B. COMMON DISEASES WITH GENETIC TENDENCIES - (within extended family)

VI. REVIEW OF SYSTEMS

(Respond by using the following key:)

Key: $\bar{o}$ = Absent

\+ = Present, requiring recorded exploration

A. General State of Health:
General well-being

Recent changes in weight

Other

B. Integumentary System:
Eruptions/Lesions

Pruritus

Other

C. Head:
Headaches

Trauma to head

Other

D. Eyes:
Date of last eye examination

Disturbances in vision

Other

E. Ears:
Recurrent infections

Disturbances in hearing

Other

F. Nose and Sinuses:
Pain
Discharges and/or post nasal drip
Obstruction
Epistaxis
Other

G. Mouth and Throat:
Date of last dental exam
Recurrent sore throat or tonsillitis
Hoarseness or change in voice
Pain, soreness or lesions
Disturbances in chewing and/or swallowing
Other

H. Respiratory:
Coughing
Wheezing
Shortness of breath
Pain
Other

I. Cardiovascular:
Chest pain
Shortness of breath
Edema
Hypertension/Hypotension
Heart Murmur
Disturbances in cardiac rate or rhythm
Other

J. Gastrointestinal:
Appetite changes
Disturbances in digestion
Jaundice
Changes in bowel habits
Constipation/Diarrhea
Blood in stool
Other

K. Genito-Urinary:
Hematuria
Kidney or bladder problems
Nocturia
Venereal disease
Impotency
Disturbances in urination
Other

L. Endocrine:
Polyuria
Polydipsia
Polyphagia
Thyroid problems
Other

M. Hematopoietic:
Bruising
Anemia
Enlarged glands
Other

N. Musculoskeletal:
Disturbances in muscles and/or joints

Other

O. Neurological:
Seizures

Memory loss

Paralysis

Sensory disturbances

Vertigo

Tremors

Syncope

Other

P. Gynecology:
Contraception

Dysparunia

Venereal disease

Breast problems

Vaginal discharges

Date of last pap smear _____

Menstrual history:

Age at onset _____ Duration _____

Frequency _____

Age, at onset of menopause_____

Obstetrical history:

No. of pregnacies _____ No. of deliveries _____

No. of abortions _____ No. of living children _____

Other

Phase II: PHYSICAL EXAMINATION

I. GENERAL SURVEY

General physical status:

General mental status:

General condition of skin:

Vital signs

BP_____ P_____ Resp_____ Weight_____ Height_____

II. HEAD AND NECK (including face, skull, neck, etc.)

III. EYES (including vision, external structures, red reflex, etc.)

IV. EARS, NOSE & SINUSES, MOUTH & PHARYNX (including hearing, external structures, tympanic membrane, nares, sinuses, membranes, teeth, gums, tongue, mucosa, pharynx, etc.)

V. CHEST AND LUNGS (including external structures, anterior-posterior diameter, excursion, fremitus, resonance, breath sounds, etc.)

VI. BREASTS (including shape and symmetry, tissues, etc.)

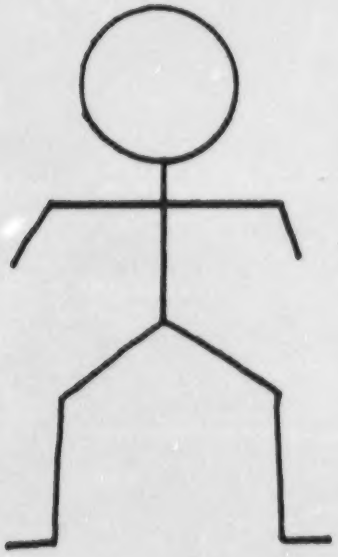
VII. HEART (including rate, rhythm, pulsations, heaves, P.M.I., thrills, heart sounds, murmurs/abnormal sounds, etc.)

VIII. ABDOMEN (including external surface, sounds, organs, abnormalities, etc.)

IX. CRANIAL NERVES

1. olfactory
2. optic
3. oculomotor
4. trochlear
5. trigeminal
6. abducens
7. facial
8. acoustic
9. glossopharyngeal
10. vagus
11. spinal accessory
12. hypoglossal

X. REFLEXES (biceps, triceps, patella, achilles, plantar)



XI. SENSORY AND MOTOR STATUS (including sensation, motor function, coordination, etc.)

Motor

Sensory

XII. BACK AND EXTREMITIES (including shoulders, hips, and any other 2 joints, muscular symmetry, abnormalities, etc.)

XIII. CIRCULATORY STATUS OF EXTREMITIES (including skin characteristics, pulses, abnormalities, etc.)

Phase III - SUMMARY

A. Records all data on the form provided.

Summary of Health Care Problems

B. Problem Statements

1. Lists 2 actual or potential health problems identified:

2. Problem-Oriented Analysis (SOAP Format) for 1 health problem identified:

PART I

HEALTH ASSESSMENT PERFORMANCE EXAMINATION

SECTION B

Simulated Heart & Breath Sounds

SIMULATION OF HEART & BREATH SOUNDS

Explanation and Suggested Learning Activities

A. HEART SOUNDS

Critical Elements	Explanation	Learning Activities
The tape for heart sounds consists of 6 simulated heart sounds. On the answer sheet provided (p. 106): 1. Check whether the sound is normal or abnormal. 2. Check the 1 most pertinent descriptor that applies if the sound is NORMAL. Or 3. Check the 1 descriptor that makes the sound abnormal if the sound is ABNORMAL. To pass this portion of the test, responses for 3 of the 6 sounds must be 100% correct; a total of 7 of the 11 heart and breath sounds must be identified with 100% accuracy. For each sound the candidate must identify if it is normal or abnormal and its descriptor.	The candidate is first required to determine whether the sound is normal or abnormal for a particular valvular area. Then the candidate must choose 1 of the descriptors that best identifies the sound. The sounds to be identified may be normal for the valvular area or abnormal such as murmur, gallop, splitting. It is not necessary to classify a murmur according to the I-VI grading system.	These sounds can be learned with actual clients in general practice and/or through simulated means as listed in the bibliography. Practice listening to the sounds. Get assistance from persons such as nurse clinicians, nurse practitioners, attending physicians, interns to validate the findings. It may be helpful to concentrate on normal sounds before focusing on the abnormal sounds.

SIMULATION OF HEART & BREATH SOUNDS

Explanation and Suggested Learning Activities

B. BREATH SOUNDS

Critical Elements	Explanation	Learning Activities
The tape for breath sounds consists of 5 simulated breath sounds. On the answer sheet provided (p. 107): 1. Check whether the sound is normal or abnormal. 2. Check the 1 most pertinent descriptor that applies if the sound is NORMAL. Or 3. Check the 1 descriptor that makes the sound abnormal if the sound is ABNORMAL. To pass this section of the test, responses for 3 of the 5 sounds must be 100% correct. A total of 7 of the 11 heart and breath sounds must be identified with 100% accuracy. In combination with the Heart sounds you must identify 7 of 11 sounds.	The candidate is required to determine whether the sounds is normal or abnormal for the anatomical location, the relationship of inspiration and expiration and the presence of adventitious sounds such as rales or rhonchi. The candidate identify only 1 descriptor that applies. When the sound is abnormal check the 1 descriptor that defines the sound. For the purposes of this examination the following is the system of classification being used: Rales are defined as fine, coarse or crepitant sounds on inspiration. Rhonchi include those inspiratory and expiratory sounds described as sibilant, sonorous or wheezing.	These sounds can be learned with actual clients in general practice and/or through simulated means from the study guide list of resources or other resources you may find. See references for print and audio tape materials. Note the different ways of classifying sounds. Practice listening to the sounds. Get assistance of someone to validate findings. Nurse clinicians, nurse practitioners, attending physicians, interns are some good sources. It may be helpful to concentrate first on the normal sounds before focusing on the abnormal sounds.

Health Assessment Performance Examination

Phase IV A - HEART SOUNDS - Answer Sheet

Name_____

SS No._____

Date_____

Directions: Write in your name, social security number and date.
Note: For your information, write in the location when given by the examiner on the tape. While you listen to the tape, you may take notes in the space provided.

As you listen to each sound, use this answer sheet to:

1. Check whether the sound is normal or abnormal.
2. Check the one most pertinent descriptor that applies if the sound is NORMAL.
3. Check the one descriptor that makes the sound abnormal if the sound is ABNORMAL.

To pass this portion of the test, responses for 3 of the 6 sounds must be 100% correct; a total of 7 of the 11 heart and breath sounds must be identified with 100% accuracy.

Tape #____

	Normal	Abnormal	$S_1 > S_2$	$S_2 > S_1$	Gallop	Murmur	Split	Notes
Sound A Location: _____								
Sound B Location: _____								
Sound C Location: _____								
Sound D Location: _____								
Sound E Location: _____								
Sound F Location: _____								

Health Assessment Performance Examination

Phase IV B - BREATH SOUNDS - Answer Sheet

Name_____

SS No._____

Date_____

Directions: Write in your name, social security number and date. Note: for your information, write in the location of the sound when given by the examiner on the tape. You may take notes in the space provided.

As you listen to each sound, use this answer sheet to:

1. Check whether the sound is normal or abnormal.
2. Check the one most pertinent descriptor that applies if the sound is NORMAL.
3. Check the one descriptor that makes the sound abnormal if the sound is ABNORMAL.

To pass this portion of the test, responses for 3 of the 5 sounds must be 100% correct; a total of 7 of the 11 heart and breath sounds must be identified with 100% accuracy.

Tape#____

	Normal	Abnormal	Broncho-Vesicular	Vesicular	Rales	Rhonchi (sibilant or sonorous)	Notes
Sound A Location: _____							
Sound B Location: _____							
Sound C Location: _____							
Sound D Location: _____							
Sound E Location: _____							

Part I - Health Assessment Performance Examination

BIBLIOGRAPHY

Directions for Use:

The Health Assessment and Teaching Performance Examination is divided into two separate sections: Part I - Health Assessment and Part II - Teaching. The Health Assessment portion of this examination evaluates the candidate's ability to perform a comprehensive assessment on a generally healthy individual. It includes a health history, physical examination, and a summary and analysis of the data. Candidates also are tested on the ability to identify and differentiate between normal and abnormal heart and breath sounds. This bibliography includes a suggested list of textbooks and other study aids to assist in assimilating knowledge and skills that will be tested. Several of these books are also included in other study guides and candidates may have some of them.

The references included in this bibliography cover both health history and physical assessment areas and are divided into categories of texts, periodicals, and audio-visuals. Candidates are encouraged to select one or more texts and use them as basic references. They should also read and use many articles, workbooks, and audio-visual aids as is necessary. It would be particularly helpful to view as many of the audio-visual aids as possible and to practice health history and assessment skills under the supervision and guidance of professional nurses skilled in this area.

Candidates are NOT expected to read all references; rather, each person is responsible for identifying areas of inadequate competence and concentration on them. Coordinated study and practice are essential.

Most of these references may be obtained from the libraries of colleges or universities, schools of nursing, medical schools, hospitals, or public libraries. Information regarding the purchase of a particular text can be obtained through bookstores or the publisher.

Primary References

EITHER

1. Bates, Barbara. A Guide to Physical Examination, 2nd ed. Philadelphia: J.B. Lippincott Co., 1979.

OR

2. Malasanos, L. et al. Health Assessment. St. Louis: C.V. Mosby Co., 2nd ed., 1981.

OR

3. Sana and Judge. Physical Appraisal Methods in Nursing Practice. Boston: Little, Brown and Co., 1976.

OR

4. Sherman, J. and Fields, S. Guide to Patient Evaluation. New York: Medical Examination Publishing Co., Inc., 3rd ed., 1978.

AND

5. Engel, G.L. and Morgan, W.L. Interviewing the Patient. Philadelphia: W.B. Saunders Co., 1973.

OR

6. Mahoney, Verdisco and Shortridge. How to Collect and Record a Health History. Philadelphia: J.B. Lippincott Co., 1976.

AND

7. Freedman, Harold and Solomon, Papper (Ed.). Problem-Oriented Medical Diagnosis. Boston: Little, Brown and Co., 1975.

OR

8. Gillies, DeAnn and Alyn, Irene B. Patient Assessment and Management by The Nurse Practitioner. Philadelphia: W.B. Saunders Co., 1976.

Secondary References

"Assessment Techniques," American Journal of Nursing
9. "Taking a Patient's History, AJN, February, 1974.
10. "Examination of the Abdomen," AJN, September, 1974.
11. "Examination of the Eye - Part I," AJN, November, 1974.
12. "Examination of the Eye - Part II," AJN, January, 1975.
13. "Examination of the Ear," AJN, March, 1975.
14. "Examination of the Head and Neck," AJN, May, 1975.
15. "Neurological Examination - Part I," AJN, September, 1975.
16. "Neurological Examination - Part II," AJN, November, 1975.
17. "Neurological Examination - Part III," AJN, April, 1976.
18. "Examination of the Chest and Lungs," AJN, September, 1976.
19. "Examination of the Heart and Great Vessels," - Part I, AJN, November, 1976.
20. "Auscultation of the Heart," - Part II, AJN, February, 1977.
21. "Examination of the Pulses," AJN, January, 1979.
22. "Examining Joints of the Upper and Lower Extremities," AJN, April, 1981.

23. Benjamin, A.D. The Helping Interview. Boston: Houghton-Mifflin, 3rd ed., 1981.

24. Brown, M.S. et al. Student Manual of Physical Examination. Philadelphia: J.B. Lippincott Co., 1977.

25. Delp, M.H. and Manning, R.T. Majors Physical Diagnosis. Philadelphia: W.B. Saunders Co., 8th ed., 1975.

26. Jarvis, C.M. "Perfecting Physical Assessment," Nursing '77, Part I, May 1977, pp. 28-37. Part II, June 1977, pp. 38.

27. Kesler and Riley. "Pitfalls to Avoid in Interviewing Out-Patients," Nursing '77, September, 1977, pp. 70-73.

28. LaMonica, L. The Nursing Process: A Humanistic Approach. Menlo Park: Addison-Weseley Publishing Co., 1979.

29. Rans, E.E. and M.M. Rans, Manual of History-Taking, Physical Examinations and Record Keeping, New York: Harper and Row Co., 1974.

30. Reynolds, J. and Logsdon, J. "Assessing Your Patient's Mental Status," Nursing '79, August, 1979, pp. 26+.

31. Sauve, M.J. and Pecherer, A. Concepts and Skills in Physical Assessment, Philadelphia: W.B. Saunders Co., 1977.

32. Seedor, M. The Physical Assessment: A Programmed Unit of Studies for Nurses, New York: Teachers College Press, 2nd ed., 1981.

33. Skydell, Barbara and Crowden, Anne S. Diagnostic Procedures: A Reference for Health Practitioners and A Guide for Patient Counseling. Boston: Little, Brown and Co., 1975.

34. Spruck, M. "An Approach to Analysis of a Symptom," Journal of Nursing Education, September, 1980, pp. 45-8.

35. Taylor, Robert. A Primer of Clinical Symptoms. New York: Harper and Row, 1973.

Audio Visuals

These materials are listed to provide assistance in health assessment. Those listed under Breath Sounds and Heart Sounds are particular to those specific areas. Most of these references you might be able to use at local medical or nursing libraries or through interlibrary loan.

Bates, Barbara: Philadelphia: J.B. Lippicott Co., 1974.
Sound motion pictures:
"The Abdomen"
"The Head and Neck"
"The Heart"
"The Female Genitalia, Anus and Rectum"
"The Male Genitalia, Anus and Rectum"
"The Musculoskeletal System"
"The Neurological Examination - Parts I and II"
"The Peripheral Vascular System"
"The Thorax"
"Pressures and Pulses"

Blue-Hill Educational System, Inc., 52 South Main St., Spring Valley, New York 10977

Video Tape Cassettes
"Part I - History Taking"
"Part II - Integument"
"Part III - Head"
"Part IV - Eyes - Parts A and B"
"Part V - Ears"
"Part VI - Nose"
"Part VII - Mouth and Throat"
"Part VIII - Neck"
"Part IX - Lymph Nodes"
"Part X - Breasts"
"Part XIA and B - Respiratory System"
"Part XIIA - Cardiovascular System - Peripheral Circulation"
"Part XIIB - Cardiovascular System - Heart"
"Part XIIC - Cardiovascular System - Heart"
"Part XIID - Cardiovascular System - Heart"
"Part XIII - Abdomen"
"Part XIV - Gynecologic Examination"
"Part XV - Genitourologic Examination"
"Part XVI - Musculoskeletal System"
"Part XVII - The neurological Examination"

Concept Media, 1500 Adams Avenue, Costa Mesa, California 92626

Filmstrips and tapes
"Physical Assessment: Heart and Lungs"
"Physical Assessment: "The Eyes" and "The Ears"

Educational Media Agency, P.O. Box 231, Old Harbor Road, Chatham, Ma. 02633 (617) 945-0565

Unit: Physical Diagnosis in Patient Assessment
PA - 01 Phys. Dx, an Overview
PA - 02 History Taking
PA - 03 Inspection
PA - 04 Palpation and Percussion
PA - 05 Auscultation
($50.00 each)

Patient Assessment Series I + II PV - 01 - 19.

Medical Electronic Educational Service, Inc., 1802 West Grand Rd. Suite 119, Tucson, Arizona 85705 (film strips + tapes)

Physical Diagnoses in Patient Assessment:
Physical Diagnoses, An Overview
History Taking
Inspection
Palpation and Percussion
Auscultation (recognizing normal + abnormal heart, breath and abdomen sounds)

National Medical Audio-visual Center, Materials Utilization Annex Station K
Atlanta, Ga. 30324

Slides and tapes
"Ophthalmoscopy: Basic Self-Instruction for Medical Students"

OMNI, Ortho Pharmaceutical Corporation, Department of Educational Services,
Raritan, New Jersey 08869

Slides, tapes, video tape cassettes
"Breast Examination"
"Teaching Breast Self-Examination"

Thiokol/Humetrics Corporation, 6374 Arizona Circle, Los Angeles, California
90045

Audio tapes
"Heart Sounds: What They Teach Us" by Antonio C. deLeon, Jr., 1975.
"The Chest: Its Signs and Sounds." by George Druger, 1974.

University of Michigan Media Library
Towsley Center for Continuing Medical Education
University of Michigan Medical Center
Ann Arbor, Michigan 48109

"Adult Physical Assessment: The Setting: The Interaction"
1121 Part I: History
1122 Part II: Physical
"Physical Appraisal of the Adult in Nursing Practice"
1103 General Techniques
1104 Eye and Vision
1106 Ear and Hearing
1108 Skin, Hair and Nails Examination
1108 Examination of the Oral Mucosa and Lymph Nodes
1109 Examination of the Respiratory System
1110 Examination of the Cardiovascular System - Part I
1111 Examination of the Cardiovascular System - Part II
1112 Examination of the Abdomen
1115 Examination of the Neuromuscular System - Part I
1116 Examination of the Neuromuscular System - Part II

Wiley Biomedical
John Wiley and Sons Inc. 605 Third Ave., New York, New York 10016

Physical Assessment of Well Adult ($75.00 each)
Unit I Introduction & Overview
Unit II Head
Unit III Neck + Extremities
Unit IV Chest + Back
Unit V Abdomen

Simulated Heart and Breath Sounds

Heart Sounds

"Heart Sounds" (tape) American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.

Tilkian, Ara G., and Mary Boudreau Conover. "Understanding Heart Sounds and Murmurs," Philadelphia: W.B. Saunders, 1979.

Breath Sounds

Cugell, David W. and Weiss, Earle B., "Introduction to Breath Sounds," American College of Chest Physicians, 911 Bresse Highway, Park Ridge, Illinois 60068. (tape)

Druger, George. "The Chest: Its Signs and Sounds," Thiokol/Humetrics Corporation, 6374 Arizona Circle, Los Angeles, Ca. 90045. (text and series of tapes)

"Lung Sounds," Stethophonics, P.O. Box 122, Wellesley, Mass. 02181. (audio cassette $15.00 each)

PART II

TEACHING PERFORMANCE EXAMINATION

PROPERTY OF THE REGENTS EXTERNAL DEGREE PROGRAM

DO NOT REPRODUCE

PART II - TEACHING PERFORMANCE EXAMINATION

CRITIAL ELEMENTS

For purposes of this examination, Teaching is defined as arranging a situation in which knowledge can be transmitted and learned. It involves the manipulation of the environment and the organization of content to enable the achievement of a specific teaching-learning objective.

This study guide is designed to assist candidates in independent study activities by directing attention to the teaching process, the specific minimum nursing behaviors that are expected for each phase of the TPE, learning references, learning activities and examples of acceptable and unacceptable responses. A sample teaching answer sheet used during the examination is included to enable candidates to practice. Two completed answer sheets are included to provide an indication of the expected level of competence.

The candidate is expected to identify a learning need, write teaching objectives, organize content and methodology to be used, specify a plan of evaluation, present the material in a live situation and evaluate the results. The content will focus on some aspects of nursing care related to health maintenance rather than to techniques requiring manipulation of equipment. NOTE: The client has already had a complete medical workup and is referred to the nurse for health teaching.

The candidate is expected to interview a client in order to identify a health related learning need, write a brief outline of a teaching plan, and implement this teaching plan with the client. The total time allowed for the entire teaching episode is one hour.

I. Components of Teaching Critical Elements

A. Planning

1. Lists one specific learning need of the client that can be met by teaching in this session.

2. Identifies data used in determining the learning need.

3. Writes one client-centered objective which can be achieved during this teaching session.

4. Outlines a teaching plan to include:

   a) Two points of content to be taught
   b) One method of presenting the information
   c) One method of evaluating the learning

B. Implementation

1. Gives the content orally as outlined.

2. Has periodic eye contact with client during teaching episode.

3. Asks questions at least once to determine client's understanding.

4. Modifies content and/or method, if client expresses lack of understanding.

5. Uses language generally consistent with client's vocabulary.

6. Uses the measure specified in the teaching plan to evaluate the client's understanding at the conclusion of the teaching - learning episode.

C. Evaluation

1. Describes the specific outcome of the teaching-learning episode in relation to the stated objective.

II. Overriding Areas (applies to all situations) and Critical Elements

A. Relating With Others

Definition:

Relating with others is behaving in a manner that facilitates the achievement of client-oriented goals and that is consistent with principles of interpersonal relations.

It is the manner in which the candidate uses and responds to verbal and nonverbal behavior in gathering information, clarifying meaning, imparting knowledge, encouraging behavior change, listening and involving the other in making decisions.

Competence in relating with others will be evaluated throughout the examination.

Critical Elements:

1. Responds in one or more of the following ways to identified nonverbal behavior(s) within the context of the situation (including gestures such as facial expression, movement, posture, tone of voice and incongruencies.)

2. Uses physical expressions that are not excessively familiar, patronizing, demeaning, abusive or otherwise unacceptable.

3. Responds in one or more of the following ways to verbal behavior within the context of the situation.

   a. Encourages the expression of ideas before making suggestions or offering solutions.
   b. Asks for validation of the behavior identified.
   c. Asks for clarification or restatement.
   d. Guides the focus of the interaction toward achieving goals.
   e. Facilitates the exploration of the topic being discussed by allowing for periods of silence or by actively commenting and questioning.

4. Uses verbal expressions that are not excessively familiar, patronizing, demeaning, abusive or otherwise unacceptable.

5. Reinforces behaviors (decisions) consistent with health care goals.

B. Clinical Decision Making

Definition: Clinical Decision-Making is a process by which logical choices are made within the context of nursing and health care based on knowledge and sound reasoning.

The competencies include obtaining data, integrating knowledge, analyzing information, making the choice from among available options and giving rationale.

The candidate will be evaluated on ability to make decisions spontaneously as well as after deliberation during the course of the examination.

Critical Elements:

1. Identifies options to present to client as potential solutions to problem situation.

2. Selects the option that is:

   a. Legal
   b. Consistent with the data presented in the situation
   c. Consistent with the client's value system
   d. Consistent with the client-oriented goals

3. Writes a rationale for decision based on:

   a. Logic
      or
   b. Scientifically based principles
      or
   c. Published literature

4. Changes decision only when dictated by new relevant data, or further analysis of existing data.

III. Study Suggestions for The Teaching Performance Examination

In preparing for the Teaching Performance Examination (TPE), candidates should think about it as an independent study "mini course", worth two semester credits. The TPE incorporates both theory of the teaching process and its implementation at the beginning professional level of competence. Candidates should be knowledgeable in both areas and be prepared to assess, plan, implement and evaluate an actual client teaching episode. The TPE is equivalent to the final examination of a college course in theory and practice of teaching. The following ideas are suggested to help the candidate plan a program of self-directed study:

1. Write on a calendar the specific hours each week for planned study of the TPE theory.

2. Read as many references in the study guide as possible but study at least 3 references pertaining to <u>each</u> phase of the TPE.

3. Practice developing hypothetical teaching assignments related to the list of potential teaching topics identified on page 122.

4. Practice writing client-oriented objectives related to teaching-learning needs of several patients. Confer with other nurses in a clinical setting who are knowledgeable in this area. The more the skill is practiced, the more likely the candidate will be able to respond to this area on the exam.

5. Practice writing actual teaching episodes using the guidelines and the teaching answer sheet found in the study guide (duplicate several copies of the form for practice.)

6. Implement actual teaching sessions planned using the critical elements in the study guide. Arrange for a qualified nurse (BSN or MSN) to observe and comment on the performance.

7. Evaluate personal teaching ability according to the critical elements. (Audio-tape teaching sessions with permission of clients).

8. Have the teaching episodes evaluated by a professional colleague skilled in clinical teaching (i.e. inservice educator, patient teacher, or collegiate faculty member.)

PART II - TEACHING

Explanation and Suggested Learning Activities

Critical Elements	Explanation	Learning Activities
A. Planning		
1. Lists one specific learning need of the client that can be met by teaching in this session.	A.1. At the beginning of the teaching episode, the candidate is assigned to a client who has a learning need in some area related to health care. The candidate is to assume that the client has already had a complete medical work-up and is referred for health teaching in the area of the assigned topic. The candidate is expected to interview the client for 10-15 minutes to determine the specific need for instruction. The candidate is expected to apply principles of interviewing and teaching-learning throughout the episode. Notes may be written during the interview and used subsequently to document the client's need for learning.	References 1, 2 or 3 may be used for the planning, implementation and evaluation phases of health teaching. References 5, 6, 8, 9, 10 and 12 may provide additional guidance. See the two examples of completed teaching answer sheets. Before coming to take the test, talk with patients, clients, family, etc. about their health status and concerns. Practice identifying their needs for specific and circumscribed health teaching. NOTE: This is a micro-teaching session which must be totally accomplished in one hour.
2. Identifies the data used in determining the learning need.	2. The candidate is expected to identify one specific need for learning and to list the information given by the client to substantiate that need.	Practice specifying the learning need and listing appropriate data used in determining the learning need.
3. Writes one client-centered objective which can be achieved during this teaching session.	3. Based on the learning need and supporting information, at least one client-centered objective must be stated in behavioral terms. Objectives should be realistic, achievable, measurable.	Practice writing client-centered objectives. References 4 and 7 may be of help in addition to all primary references.

	They should also include the desired outcome and a time frame of when they will be evaluated. Examples of acceptable objectives: "Following a 15 minute teaching session, the client will be able to identify two foods in each of the basic fours." Or "Given a list of foods, the client will be able to list (or identify, state, etc.) foods high in protein."	
4. Outlines a teaching plan to to include: a) Two points of content to be taught. b) One method of presenting the information. c) One method of evaluating the learning.	4. The teaching plan should be very concise, specific and meet the three stated critical elements. It should reflect the specific learning need and stated objective. This must be written on the teaching answer sheet prior to beginning implementation. After the initial interview of 10-15 minutes, candidates should allow 20-25 minutes for the planning phase.	Reference 10 may be of particular assistance here. Practice writing a teaching plan related to an identified need, using the critical elements as a guide. Validate the plan with the "client" and/or other nurse professional.
B. Implementation 1. Gives the content orally as outlined. 2. Has periodic eye contact with client during teaching episode. 3. Asks questions at least once to determine client's understanding. 4. Modifies content and/or method, if client expresses lack of understanding. 5. Uses language generally consistent with client's vocabulary.	B 1-6. The candidate is allowed no more than 15 minutes to actually teach the client. Each critical element must be met as stated.	Practice teaching "clients" actually applying each critical element and the principles found in the references. Use this approach at your job (if it is appropriate) to gain additional and more realistic experience. Practice having a professional nurse observe your teaching episodes, with the critical elements in hand, to assure that each one is being met with 100% accuracy.

6. Uses the measure specified in the teaching plan to evaluate the client's understanding at the conclusion of the teaching-learning episode.	Be sure to evaluate the client's understanding of the content by using the method indicated in the plan.	
C. Evaluation		
1. Describes the specific outcome of the teaching-learning episode in relation to the stated objective.	C1. After the teaching-learning episode with the client is finished, write a statement on the Teaching Answer Sheet under Evaluation that indicates whether or not the learning objective was achieved by the client. Provide some evidence that the client learned or did not learn. In addition, list or describe any changes you would make in your teaching plan. You should plan to complete this phase in 5-10 minutes. An omission of this critical element as with other critical elements - means failure of this part of the examination.	The evaluation phase is just as important as the planning and implementation phases.

Teaching Performance Examination

Potential Teaching Topics

To be consistent with the content in the other REDNP examinations, the teaching topics used in this examination have been divided into two categories: those which relate to Health Support and others which focus on Health Restoration. Health Support topics relate to areas which influence a client's wellness, such as the client's activity, sustenal, developmental and sociological patterns. Health Restoration topics relate to areas which assist the client in returning to wellness, such as counseling in regard to treatment, alleviation, adaptation or rehabilitation methods.

The content to be taught must be individualized according to the learning needs of the client, and must focus on knowledge of some aspect of health care, maintenance or prevention, rather than on techniques or "how to do" something.

Health Teaching Topics Related to Health Support

1. Allergies
2. Alterations of ADL (i.e. insomnia, lack of planned exercise, meal planning, gastro-intestinal problems.)
3. Birth control
4. Change of life style (i.e. "empty nest syndrome, loss of loved one, retirement.)
5. Child development (i.e. in relation to safety, stress, sibling rivalry, prehospitalization preparation.)
6. Constipation
7. Diet - (i.e. maintaining or losing weight, balanced daily nutrition etc.)
8. Family history of illness (i.e. endocrine, cancer, respiratory, cardiovascular.)
9. Headaches
10. Health maintenance procedures - (i.e. GYN exam, x-rays, self-breast exam, immunizations.)
11. Premenstrual/menstrual discomforts
12. Smoking

Health Teaching Topics Related to Health Restoration

1. Acne
2. Coping with major illness (i.e. cardiovascular, respiratory, endocrine, cancer.)
3. Diabetic teaching
4. Diet in relation to illness (i.e. cholecystitis, anemia, ulcer, colitis, diabetes etc.)
5. Discharge and/or home planning (i.e. alterations of home environment to care for ill family member returning home - fractures, paralysis, decreased sensory functions.)
6. Negative health practices - (i.e. misuse/abuse of drugs, alcohol, interactions of over-the-counter medicines and misuse of prescription drugs.)
7. Proper use of equipment (i.e. pacemaker, hearing aid, elastic stockings etc.)
8. Venereal disease.

THE UNIVERSITY OF THE STATE OF NEW YORK
REGENTS EXTERNAL DEGREE PROGRAM
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

OFFICE OF INDEPENDENT STUDY
PROGRAMS DEVELOPMENT
DEGREE PROGRAMS IN NURSING
518: 473-8957

TEACHING ANSWER SHEET

Candidate's Name Jane Doe Date July 1, 1979

NOTE: Use the back of this paper to take notes during the interview in which you will identify the teaching need.

Preliminary Summary:

Briefly state the health care problem for which teaching is necessary and summarize the characteristics of the client that are directly related.

Obesity with difficulty in following diet. Client is 25 year old female, advised to lose 20 pounds. She agrees with need to reduce but continues to eat high calorie diet.

Planning:

1. One Learning Need of Client:

   To plan a balanced diet which will facilitate weight reduction.

2. Data Used in Determining Learning Need: (Information Used to Substantiate Need)

   Client lacks knowledge in planning a reducing diet. She chooses foods high in calorie value and snacks frequently. Client is overweight and expresses a desire to reduce weight. Has been unsuccessful in attempts to lose weight.

3. One Client-Centered Learning Objective to Be Achieved:

Following the Teaching session the client will be able to select foods from the basic four and plan a balanced 1500 calorie diet for 1 day.

4. Teaching Plan:

a) Two Major Points of Content to Be Taught:

1. Foods included in the basic four food groups.

2. Calorie values and how they influence weight reduction.

b) One Method of Presenting Content:

Discussion of information found in pamphlet which describes basic four food groups and calorie values.

c) One Method of Evaluating Client's Understanding:

Have the client write out a diet plan for 1 day.

Implementation:

Evaluation:

1. Statement of Outcome of the Teaching-Learning Episode (To Be Completed After the Content Has Been Presented):

Client presented a written 1 day meal plan which included basic four food groups that was limited to 1500 calories. Client expressed desire to try harder to lose weight by complying with the plan.

THE UNIVERSITY OF THE STATE OF NEW YORK
REGENTS EXTERNAL DEGREE PROGRAM
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

OFFICE OF INDEPENDENT STUDY
PROGRAMS DEVELOPMENT

DEGREE PROGRAMS IN NURSING
518: 473-8957

TEACHING ANSWER SHEET

Candidate's Name Mary Smith Date July 1, 1979

NOTE: Use the back of this paper to take notes during the interview in which you will identify the teaching need.

Preliminary Summary:

Briefly state the health care problem for which teaching is necessary and summarize the characteristics of the client that are directly related.

Client has "difficulty sleeping." She sometimes has difficulty falling asleep, but more frequently awakens at 4 a.m. She gets up at this time, since she cannot return to sleep. She has tired various remedies, i.e., hot milk. Being more active during day, and just "lying there" unsuccessfully.

Planning:

1. One Learning Need of Client:

   Client needs to learn a method of relaxation that will allow her to return to sleep.

2. Data Used in Determining Learning Need: (Information Used to Substantiate Need)

   The client's main concern is not falling to sleep initially, thus, hot milk, increased acitivity, and "lying there" may not prove successful. A relaxation method of breathing and muscle control will allow her to decrease tension and fall back to sleep.

3. One Client-Cenetered Learning Objective to Be Achieved:

   After demonstration, the client will demonstrate relaxation of the arms and neck with breathing.

4. Teaching Plan:

   a) Two Major Points of Content to Be Taught:

      A. The concept of conscious muscle relaxation

      B. Breathing control

   b) One Method of Presenting Content:

      Demonstration for the client of the techniques of relaxation

   c) One Method of Evaluating Client's Understanding:

      Have client return the demonstration by asking her to relax arm and neck muscles in combination with controlled breathing

Implementation:

Evaluation:

1. Statement of Outcome of the Teaching-Learning Episode (To Be Completed After the Content Has Been Presented):

   Client seemed to comprehend the material covered in the Teaching session. She was able to return my demonstration of upper body relaxation, and appears to be willing to try this method of promoting sleep.

THE UNIVERSITY OF THE STATE OF NEW YORK
REGENTS EXTERNAL DEGREE PROGRAM
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

OFFICE OF INDEPENDENT STUDY
PROGRAMS DEVELOPMENT

DEGREE PROGRAMS IN NURSING
518 473-8957

TEACHING ANSWER SHEET

Candidate's Name _____ Date_____

NOTE: Use the back of this paper to take notes during the interview in which you will identify the teaching need.

Preliminary Summary:

Briefly state the health care problem for which teaching is necessary and summarize the characteristics of the client that are directly related.

Planning:

1. One Learning Need of Client:

2. Data Used in Determining Learning Need: (Information Used to Substantiate Need)

3. One Client-Centered Learning Objective To Be Achieved:

4. Teaching Plan:

   a) Two Major Points of Content to Be Taught:

   b) One Method of Presenting Content:

   c) One Method of Evaluating Client's Understanding:

Implementation:

Evaluation:

1. Statement of Outcome of the Teaching-Learning Episode (To Be Completed After the Content Has Been Presented):

BIBLIOGRAPHY

Directions for Use:

The Teaching portion of this examination tests a candidate's ability to identify a client's learning needs, the objectives, content and methodology to be used for the brief teaching episode, and to present it in a live situation. The candidate is tested on the content presented to clients related to their health care need, as well as on the teaching process. Candidates should be prepare to present content appropriate to each of the health teaching topics listed on page 122. The candidate must also evaluate and record the outcome of the teaching-learning episode. This bibliography includes a suggested list of textbooks, and other study aids to assist in assimilating knowledge and skills that will be tested. Several of these books are also included in other study guides and may already be familiar to candidates.

The references included in this bibliography cover client teaching and learning in nursing practice, and are divided into these categories. Candidates are encouraged to select one or more primary texts and use them as basic references. Candidates should also make use of visual aids where possible and practice teaching skills under the supervision and guidance of professionals skilled in this area.

Candidates are NOT expected to read all references; rather, each person is responsible for identifying areas of inadequate competence and to concentrate on them. Coordinate study and practice are essential.

Most of these references may be obtained from the libraries of colleges or universities, schools of nursing, medical schools, hospitals or public libraries. Information regarding the purchase of a particular text can be obtained through bookstores or the publisher.

A. References for Client Teaching and Learning

Primary References

EITHER

1. Guinee, Kathleen K. Teaching and Learning in Nursing. New York: Macmillan Publishing Co., 1978.

OR

2. Redman, Barbara K. The Process of Patient Teaching in Nursing 4th ed. St. Louis: C.V. Mosby Co., 1980.

OR

3. Zander, Karen S. and Bower, Kathleen A. Practical Manual for Patient-Teaching. St. Louis: C.V. Mosby Co., 1978.

AND

4. Mager, Robert. Preparing Instructional Objectives. 2nd ed. California: Fearan Publishing Co., 1975.

Secondary References

5. Bille, Donald A. Practical Approaches to Patient Teaching. Boston: Little, Brown and Company, 1981.

6. DelBueno, Dorothy. "Patient Education: Planning for Success," Journal of Nursing Administration, June, 1978.

7. Greenlund, H.E. Measurement and Evaluation in Teaching. New York: The Macmillan Co., 1976.

8. Gusfa A., Christoff V. and Headley, L. "Patient Teaching - One Approach," Supervisor Nurse, December 1975.

9. Huckabay, L.M. Conditions of Learning and Instruction in Nursing:Modularized St. Louis: C.V. Mosby Co., 1979.

10. Jones, Patricia and Oertel, William. "Developing Patient Teaching Objectives and Techniques: A Self-Instructional Program," Nurse Educator, September-October 1977.

11. Kozier, Barbara and Erb, Glenora L. Fundamentals of Nursing: Concepts and Procedures. Chapter on "Teaching and Learning." Menlo Park, California: Addison-Wesley Publishing Co., 1979.

12. LaMonica, Elaine L. The Nursing Process: A Humanistic Approach. Menlo Park: Addison-Wesley Publishing Co., 1979.

13. Little, Dolores C. and Carnevali, Doris L. Nursing Care Planning. Philadelphia: J.B. Lippincott Co., 1976.

14. Murray, R. and Zentner, J. "Guidelines for More Effective Health Teaching," Nursing '76, February 1976.

15. Narrow, Barbara W. Patient Teaching in Nursing Practice. New York: John Wiley and Sons, 1979.

16. Redman, Barbara K. Issues and Concepts in Patient Education. New York: Appleton-Century-Crofts, 1981.

17. Redman, Barbara K. Patterns for Distribution of Patient Education. New York: Appleton-Century-Crofts, 1981.

Audio Visuals

Fairview General Hospital Patient Education Series, Cleveland, Ohio

Part I - "The Teaching Learning Process"
Part II - "Writing Behavioral Objectives"
Part III - "The Evaluator Process"

B. References for Teaching Topic Content

1. Chinn, Peggy L. Child Health Maintenance, 2nd ed. St. Louis: C.V. Mosby Company, 1979.

2. Clark, Ann, et al. Childbearing: A Nursing Perspective, 2nd ed. Philadelphia: F.A. Davis, 1979.

3. Hogan, Rosemarie. Human Sexulity: A Nursing Perspective. New York: Appleton-Century-Crofts, 1980.

4. Jones, Dorothy, et al. Medical-Surgial Nursing: A Conceptual Approach New York: McGraw-Hill, 1978.

5. Kyes, Joan J. and Charles K. Hofling. Basic Psychiatric Concepts in Nursing. New York: Harper-Row, 1980.

6. Luckman, Joan and Karen Sorenson, Medical-Surgical Nursing: A Psychophysiological Approach, Philadelphia: W.B. Saunders Co., 1980.

7. Whaley, Lucille and Donna Wong. Nursing Care of Infants and Children. St. Louis: C.V. Mosby Co., 1979.

1/82